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ABSTRACT

This document provides guidelines for individuals giving health care to adolescents through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Chapter One briefly indicates needs of adolescents and outlines legal aspects of health care for adolescents such as age of majority, informed consent, confidentiality, disclosure of information, and right of refusal. Suggestions likely to be helpful in the administration of EPSDT services for adolescents are provided in Chapter Two. Chapters Three and Four offer guides to obtaining a complete health history and giving a physical examination to an adolescent, respectively. Chapter Five reviews screening procedures and referral for diagnosis and treatment. Among the 19 screening areas covered are nutritional status, dental care, vision, hearing, hypertension, and special medical problems of adolescents such as acne and allergies. Special hazards of adolescence such as abuse, neglect, delinquency, sexual exploitation, accidents, drug and substance abuse, sexual activity and pregnancy are discussed in Chapter Six. In conclusion, Chapter Seven provides a review of adolescent emotional development which explores the adolescent's response to responsibility, achievement, interpersonal relationships, interpersonal balance, and recreation. (Author/RH)

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a guide to

ADOLESCENT HEALTH CARE

EPSDT

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Care Financing Administration

in cooperation with

The Interagency Committee on Early and Periodic Screening, Diagnosis, and Treatment

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On April 1, 1980, the Department of Health, Education, and Welfare was redesignated as the Department of Health and Human Services.

Therefore, all references to the Department of Health, Education, and Welfare or to HEW contained herein apply to the Department of Health and Human Services.

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Health Care Financing Administration
in cooperation with
The Interagency Committee on Early and Periodic Screening, Diagnosis, and Treatment

The Health Care Financing Administration (HCFA) was established in March 1977 to combine HEW's health financing and quality assurance programs into a single agency. HCFA is responsible for the operation of the Medicare and Medicaid programs, the Professional Standards Review Organization (PSRO), Federal survey and certification efforts, and a variety of other health care quality assurance activities.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries - approximately 45 million aged, disabled, and poor Americans. HCFA is committed to making beneficiaries aware of the services for which they are eligible, promoting the accessibility of those services and ensuring that HCFA policies and actions promote efficiency and quality within the total health care delivery system.

The Office of Child Health (OCH) within HCFA is responsible for administering the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) under Medicaid. This publication was prepared by the Office of Child Health.

PREFACE

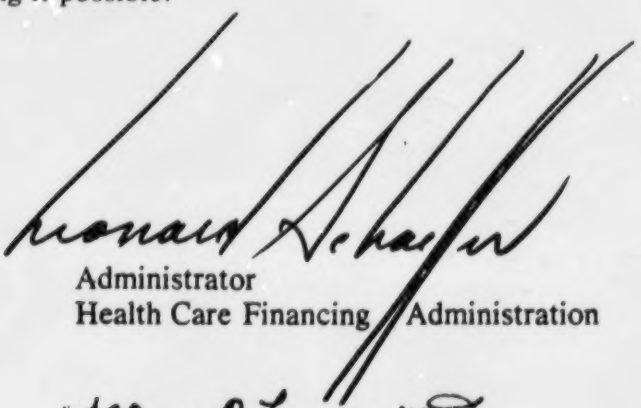
The substantive material in this "Guide to Adolescent Health Care EPSDT," was developed initially in 1975 by an HEW Interagency Committee on Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), a committee that represented expertise in a wide range of disciplines. Its final report was in the form of recommendations for services to adolescents under the EPSDT program (included under Title XIX of the Social Security Act). These technical recommendations were adapted for use by EPSDT practitioners by Lorene Stringer, MSW and Helen Martz, Phd. This document reflects their insight and sensitivity to adolescent concerns developed through many years of experience in dealing with the health problems of children and youth.

This Guide is directed to State and local agencies, providers, and others involved in implementing EPSDT. It is equally applicable to the requirements of the proposed Child Health Assessment Act (CHAP) reintroduced in Congress in 1979. It was developed in response to an increasing number of requests for technical assistance in providing health care to adolescents under the EPSDT program. It can provide a basis for setting standards of good practice in planning and delivering EPSDT services to adolescents.

This pamphlet is the sixth in a series of publications relating to various aspects of EPSDT. The first, "A Guide to Screening," was prepared in cooperation with the American Academy of Pediatrics; the second, "A Guide to Dental Care," in cooperation with the American Society of Dentistry for Children and the American Academy of Pedodontics; the third, "A Report on Professional Health Provider Participation," with the American Medical Association's Committee on Health Care of the Poor; the fourth, "A Guide to Administration, Diagnosis, and Treatment," with the American Academy of Pediatrics under a contract with the Health Services and Mental Health Administration; and the fifth, a group of informational booklets on "Overview," "History," "Orientation," "Clients," "Child Health," and "Service Tasks," with accompanying training materials: "Orientation Training" and "Problem Solving

Training," developed by the EPSDT Training Materials Development Project, University of Michigan, under a grant from the Public Services Administration, Office of Human Development, HEW.

We are grateful to the Interagency Committee for the careful thought and extensive effort put into developing this material, and to the Public Health Service for making it possible.



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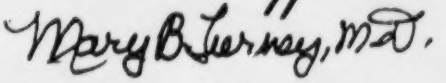

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INTRODUCTION

Adolescents are "tween-agers." They are no longer merely children, but not yet fully adult. They still harbor many of the feelings they had as children, but experience strange new feelings as well, and at the same time are told (in quick alternation and with confusing frequency) that they are "too old" for this and "too young" for that.

The task of growing up is arduous and long, generally spanning the years from 10 to 21. Starting at puberty, the time at which sexual maturation makes reproduction possible, adolescence is the period during which young peole are expected to develop emotional, social, and intellectual maturity and control. Puberty does not occur at a specific age; onset may vary within several years, and a group of normal youngsters all 13 years old will show a wide range of sexual and psychological maturation. They cannot be evaluated by chronological age alone. Each must be evaluated individually.

Fortunately, a few broad statements about adolescents still hold true. However much the timing may vary between individuals, most go through three stages in these years. In early adolescence, 10 to 14 years, physical changes are taking place rapidly, and the central struggle is to try somehow to get comfortable with one's own body while it keeps changing. One is acutely aware of others and their expectations, though never clear about exactly what it is that others expect. In middle adolescence, 15 to 17 years, the physical changing slows down and the psychosocial changing speeds up, bringing turbulence and rebellion to full height and consciousness. Claims to independence are intermixed with tirades against the demands of society; but now and again, in the midst of acting or talking out, one gets a brief but firm grip on a sense of self. In late adolescence there is a beginning of stabilization, a feeling of becoming more predictable, more responsible, more one's own person and, therefore, better able to think about the future, even to plan for it, perhaps to take some tentative steps toward it.

It is not altogether the fault of society that health services for adolescents have always been woefully wanting almost everywhere. For one thing, health services are a part of "the establishment" against which

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adolescents are in rebellion. Their striving for independence makes them ill-suited to the role of patient, passive, and subject to some medical authority. But beneath this are the very private, exquisitely sensitive feelings engendered by the growing-up process itself; much anxiety about one's body-image, much longing to have one's body as like as possible to the bodies of one's own sex peers, and great fear that exposure and examination will uncover some defect until now undetected.

On the other hand, most teenagers develop close ties to their age-mates of both sexes. While they are still groping for a sense of individual identity, they want, above almost anything else, to be accepted by their peers. If possible, to be liked and even admired by them but, in any case, to be accepted. They try to think alike; talk alike; and dress, eat, drink and genenally behave alike. They also begin to feel urgings toward a close relationship with someone of the opposite sex. In most adolescents these gregarious impulses are compellingly strong. Along with opening up new potentials for growth, they also open up new needs and new risks, and possible problems connected with sexual activity, addictive behavior, and with social-emotional concerns.

What we have to deal with is not that adolescents have no problems, or think they have no problems, but simply that they refuse, short of needs that bring them into the emergency room of a hospital, the kinds of help that we have usually offered them. They want and are likely to use health services that are tailored to their particular concerns and provided by people who understand and duly respect their special sensitivities. We are not yet so far advanced in our society as to offer such health services to all adolescents. But under the EPSDT mandate we are encouraged—obliged—to offer them to those who have, in addition to all the "normal problems of adolescence, the further problems induced by poverty. It could happen that, by addressing ourselves to the development of comprehensive health services for EPSDT youth, we may find better ways to promote the growth and maintain the health of all young people.

CHAPTER I

THE NEEDS OF ADOLESCENTS

Comprehensive health services for adolescents are not necessarily broader in scope or more complicated in detail than comprehensive health services for any other age group. Each age group has its own particular needs, and within each age group the needs of every individual are particular, too. The one need common to all groups and individuals is that their particularities should be as clearly recognized and respected as their similarities.

There are two differences, that should distinguish adolescent health services from services for other age groups: first, they have greater potential for preventing permanent disabilities; and second, the peer group is of prime importance. Peer pressure can be used to enlist the interest and cooperation of adolescents in order to most effectively prevent disabilities. In addition, adolescents are not interested in preventive health care. They will be interested, however, in what will improve their body image.

They do not live with the future weighing heavily on their minds. They are immersed in the present. Health education is a bore. Health habits are irksome consumers of precious time. Very few among them are going to get exercised about nutrition as a factor in iron-deficiency anemia and its sequelae of low energy and high proneness to infections. But give them solid information about which foods are likely to leave them scrawny or make them fat, or contribute to a clear complexion or sound, good-looking teeth, and they will listen, absorb, and act upon it. They will pour time and effort unstintingly into learning what they want to know, and into any task of personal hygiene that promises to make them more pleasing to themselves and more attractive to their friends.

When adults accept these facts, they can work with teenagers toward comprehensive health care. Thus, they will tolerate the periodic updating of their immunizations; the periodic assessments of growth and develop-

ment, vision, hearing, dental, and school achievement; and other relevant screening tests that are deemed important.[1]

Adolescents may pretend to have no interest in what those tests reveal, but they will appreciate candid talk about the results, good, bad, or indifferent. They should be given that information. They have a right to it.

In similar fashion, health education should include and highlight the things that teenagers want to know: sex education; family life education; social problems that impinge upon their lives; and the intricacies, costs, and rewards of interpersonal relationships. All that they need to know can follow naturally in the wake of their learning what they want to know. To care profoundly about oneself and how one appears and appeals to one's peers is not only normal in adolescence, it is a hallmark of health. The young person to worry about is the one who does not care in these ways.

Nothing is so important to the success of an adolescent health program as the ability of the staff to relate to young people in an understanding manner, with full respect for their sensitivities and right to personal privacy. An orientation course for all health personnel is indispensable, but not by itself sufficient. Because adolescents are complex and often in a state of change, all staff should have continuing in-service training and access to skilled supervisory and consultant personnel. If at present that seems more like a dream than an achievable reality, it is nevertheless a dream to hold on to and work toward.[2]

Legal Aspects of Health Care for Adolescents

Young people often do not receive needed health services because of the assumption that they must have parental consent to seek medical care. When the care is needed for suspected pregnancy or venereal disease, many adolescents will forego medical attention rather than reveal their fears to their parents.

Recently there has been a substantial increase in recognition of the rights of youth to medical care in general, contraception, abortion, and treatment of venereal disease. These issues are governed by State laws, and health care providers should familiarize themselves with the laws of

1. "A Guide to Screening - EPSDT-Medicaid," Social and Rehabilitation Service in cooperation with the American Academy of Pediatrics, U.S. Dept. HEW, Washington, D.C. 1974.
2. "EPSTD: The Possible Dream," Health Care Financing Administration, U.S. Dept. HEW, Washington, D.C. 1977.

the State in which they work. State laws also determine welfare eligibility, and therefore, payment under EPSDT for medical services.

In particular, the major legal questions to be noted are:

Age of majority

Virtually all States have lowered the age of majority to 18. Almost half of the States now have medical consent laws permitting minors to obtain medical services for themselves in varying contexts. Many more have laws giving minors access to medical services in those situations in which they are exposed to high medical risks. All States and the District of Columbia permit minors to consent to treatment for venereal disease.[3]

Informed consent

Recommended procedures or referrals for further evaluation of treatment should be explained in a way that leaves no question in the minds of adolescents about what they are committing themselves to by signature. Informed consent can be based only on full information about the procedures involved and their implications.

Confidentiality

Medical consent laws entitle signatories to full confidentiality. When young people are in trouble, every reasonable effort should be made to persuade them to seek parental support (even when it is not required by State law). However, the adolescent who has legal right to sign a medical consent form also has the legal right to refuse permission to transmit any medical information to others.

Disclosure of information

When it appears to be to the adolescent's benefit to share certain health-related facts with family, school, or other community agency, the adolescent must sign a formal agreement to such disclosure. The step should be discussed in detail and full agreement reached between patient and health professional as to exactly what information may be disclosed, and the specifics should be explicitly stipulated on the disclosure consent form.

Right of refusal

In accordance with Section 1907 of the Social Security Act, no person eligible for services under Title XIX may be compelled to undergo any medical

3. "Pregnancy, Teenagers, and the Law: 1977," by Nancy Gilbert Grenner, Harriet F. Pilpel, and Eva W. Paul; the Alan Guttmacher Institute, Washington, D.C. (Draft)

screening, diagnosis, or treatment if the person (or, in the case of children, their parents or guardians) objects to such services. Adolescents legally entitled to sign medical consent forms are also legally entitled to refuse medical care. Refusal to answer questions about certain kinds of activities may not affect the provision of other screening, diagnostic, or treatment services.

CHAPTER II

ADMINISTRATIVE CONSIDERATIONS IN EPSDT PROGRAMS

The following suggestions may be helpful in the administration of EPSDT services for adolescents.

Goal

It should be clear to everyone involved that the goal of the EPSDT program is the establishment of a full range of health services: outreach, case-finding, health education, prevention of illness, screening, diagnosis, treatment, follow-up, health maintenance and health-related support services.

Focus

The local health coordinator, specifically responsible for implementing the adolescent component of the EPSDT program, should arrange for appropriate use of available resources, work toward developing other needed resources, and establish and maintain effective liaison between the local community and relevant State and Federal agencies.

Population

The eligible population should be identified and described in terms of numbers, age, residence, and other pertinent demographic characteristics. By law, all eligible families must be informed of existing services. Outreach to school dropouts and young adults requires special attention. Separate identification cards should be issued to all eligible children and youth over the age of 12 years. Although parents should participate wherever possible in health care for their children, needed (and legally permitted) services should not be withheld or delayed because of parental non-participation.

Records

Individual health records should be maintained and held confidential. They should contain data on services rendered, clinical findings, and case management decisions including referrals and results of referral. Each record should be periodically reviewed and evaluated by a qualified professional who should decide on any needed further action, and take steps to ensure its implementation. No information from these records should be transmitted without the signed and informed consent of the adolescent, or, in the case of subject-incompetence, the parent or guardian, without specifying what is to be transmitted and to whom, and without reasonable assurance that such transmittal is for the adolescent's benefit.

Focus and Feedback

Since adolescents are the focus of the program, open communication between health professionals and their young clients is essential. There should be bilingual, bicultural personnel in the areas where English is not the only language spoken and understood. At the outset, adolescents should be informed about their rights and about the range of services available. It is helpful to have this material in printed form for them to keep for reference.

Before every testing or screening procedure, its purpose should be clearly explained, and after each procedure the results should be conveyed in clear and simple terms, and in an unhurried and sufficiently private situation to afford opportunity to talk about sensitive questions and personal concerns. In the context of a mutually trusting and candid relationship, adolescents can more easily develop a sense of responsibility for their own health care. Finally, it is of inestimable value to encourage the development and maintenance of a Youth Advisory Council to assist in program planning, the ordering of priorities, and evaluation of services.

Resources

Policies and procedures for collaboration with other social institutions and agencies should be clearly defined, and always in terms that safeguard the rights and well-being of adolescents. Local EPSDT programs are necessarily shaped by the availability of resources as well as by the

skills and understanding of the staff and the ability of the director to enlist community support for development of needed resources. The EPSDT agency should explore the provisions of all current State laws relating to its functions and should formulate and disseminate to all potential EPSDT providers guidelines for action pursuant to the law. The following list, though not comprehensive, includes some of the most frequently used resources:

- Medical Centers; Departments of Pediatrics and Adolescent Medicine
- Community Hospitals
- Protective Services
- School Health Services; Special Education Programs for Handicapped Children
- Health Departments: Title V—M & I, C & Y, CC Programs, Neighborhood Health Centers, VD, TB and Immunization Programs, Prenatal and Family Planning Clinics
- Mental Health Clinics
- Freestanding Clinics
- Group Health Clinics: HMOs, Private Group Practices
- University-affiliated Diagnostic Centers (DD)
- Drug and Alcohol Rehabilitation Programs
- Vocational Counseling and Rehabilitation Services
- Learning Disability Programs
- Family Service Agencies
- Parent Groups
- Religious and Secular Service Organizations
- Private Practitioners

Accountability

Reporting systems should include not only patient visits and services, but also the proportion remaining unserved in the eligible population, and estimates of unmet needs.

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CHAPTER III

THE HEALTH HISTORY

A complete health history should include assessments and all significant details of germane family background factors: of the prenatal, natal, and neonatal periods; of developmental milestones; health habits and attitudes; and the usual reviews of systems and of illnesses, immunizations, allergies, accidents, hospitalizations or visits to a hospital emergency room; and past and current disabilities.

To obtain and record such a comprehensive history is obviously a time-consuming task, but it can be a highly productive one as well, initiating the kind of relationship essential to good health care. If done with skill born of knowledge, experience, and intuitive sympathy, it is also: 1) an excellent screening tool; 2) a good, brief course in health education for the adolescent; and 3) a useful guide to health-supporting measures. If a parent is available to supply information about the adolescent's start in life, some portion of the history-taking interview should include the parent. Still, it is important to keep the adolescent actively engaged and in central focus throughout the process, and alone with the interviewer for enough of the time to ensure privacy and confidentiality.

One particular possibility should be noted and safeguarded against. In broken families, and often in very large or overstressed families, a good deal of information may have been lost. This can be quite damaging to an adolescent's sense of self and worth. When there is evidence that information is thus missing, the interviewer should be advised not to press unreasonably, but to turn to current issues. It is better to forego the history altogether than to add unnecessarily to anxiety or unhappiness.

Both because of the above consideration and because there is not always time enough to obtain a full health history it is a good idea to ask the adolescent to fill in a printed questionnaire before being seen (see the example on pages 11-12. This should be requested as a passing and routine procedure so that it can be casually dismissed if it seems to pose any appreciable problem. Its purpose is not so much to obtain factual

information as to elicit clues for moving easily and tactfully into discussing concerns of special importance to the young person.

The Outline for Adolescent Health History (pages 13 through 16) suggests an organization of historical data for ready reference. Sections A, B, and C may be used to direct the interview through the getting-acquainted stages. Sections D and E cover more difficult, personal, and sensitive areas of great importance. The items are by no means comprehensive and are intended chiefly to remind the interviewer of the various aspects to be considered in developmental review and psychosocial assessment. How this information is obtained and evaluated depends almost entirely on the interviewer's skill and judgment. Note, however, that reference can be made here to the adolescent's responses on the Questionnaire. Those responses can help in formulating further questions in appropriate and tactful terms.

If the interviewer is not the professional who will conduct the physical examination, it is all the more essential that the recorded health history conclude with a note about that adolescent's special points of sensitivity, special areas of vulnerability, degree of need for reassurance, and mode in which that need can best be met. The accuracy and pertinence of this Staff Note can go far toward ensuring optimal treatment of the adolescent.

INTRODUCTORY HEALTH QUESTIONNAIRE*

Please respond to the following questions by circling "Yes" or "No." When you are called, take this sheet with you and hand it directly to the interviewer. It will be held confidential in your medical record.

1. Are you satisfied with your general health?	Yes	No
2. Do you go to a dentist regularly to have your teeth cleaned and checked?	Yes	No
3. Are you satisfied with the way you are growing?	Yes	No
4. Are you satisfied with your weight?	Yes	No
5. Do you think you can answer most questions about your health history?	Yes	No
6. Do you have any allergies?	Yes	No

7. Do you eat fruit or drink fruit juices every day?	Yes	No
8. Do you eat vegetables every day?	Yes	No
9. Do you often snack between meals?	Yes	No
10. Do you take vitamins, iron, or other dietary supplements?	Yes	No
11. Are you on a special diet?	Yes	No
12. Do you have concerns about drinking alcohol or using drugs?	Yes	No
13. Has your school work been generally satisfactory?	Yes	No
14. Do you work regularly or frequently to earn money?	Yes	No
15. Would you like to obtain printed information or to talk about any of the following? (If yes, identify by check below)	Yes	No

—Health
—Emotions (feelings)
—Getting along with family
—Getting along with friends
—Dating
—Sex
—Pregnancy
—Birth control
—Smoking
—Alcohol
—Drugs
—Work
—School
—How to cope with stress
—Other (specify)

*Adapted from the Questionnaire developed by Charlotte Levine, M.D., for the Mile Square Health Center, Inc., Chicago, Illinois.

OUTLINE FOR ADOLESCENT HEALTH HISTORY

Date _____

Name _____

Date of Birth _____

Place of Birth _____

Race _____

Sex _____

Grade Level _____

Specific Complaints: 1. _____

2. _____

3. _____

PAST HISTORY

A. Personal Medical

1. Usual childhood illnesses (rated mild, moderate, severe)
2. Other severe illnesses, including hospitalizations
3. Surgical procedures
4. Accidents
5. Allergies and drug-reactions
6. Prescription and other medications (e.g., insulin, antihistamines, anti-convulsants, birth control pills, aspirin, amphetamines, or prophylactics)
7. Disabilities
8. Immunization status

B. Family

1. Father: age, occupation, chronic illnesses (including diabetes, cancer, heart disease, hypertension, mental illness, alcoholism, etc.)
2. Mother: (as above)
3. Siblings: (as above, listing by birth-order)
4. Others in household: (as above, including relationship, if any)
5. Living arrangements: (number of rooms, number and relationship of occupants, who carries responsibility for specific family functions, etc.)

C. Review of Systems

1. Eyes: vision, strabismus, glasses, headache
2. Dental: previous care, pain, infection, cosmetic concerns
3. ENT: earache, hearing, sore throat, frequent colds, hay fever
4. Skin: rash, acne, infections, scars, moles
5. Cardiovascular: palpitation, murmur, shortness of breath
6. Respiratory: asthma, pneumonia, cough, TB
7. Gastrointestinal: "stomach upsets," pain, vomiting, diarrhea, constipation, bleeding, worms, rectal discharge
8. Genito-urinary: enuresis, frequency, urgency, pain, infection, urethral or vaginal discharge or bleeding
9. Endocrine: growth, secondary sexual development, menarche, menstrual pattern, pregnancy or fathering, contraceptive measures

10. Musculoskeletal: bone or joint pain, braces, back problems

11. Central nervous system: convulsions, headache, vertigo, fainting spells

D. Development and Behavior

1. Birth and first two years: where mental retardation or developmental disability is suspected, a fuller history should be obtained from the parents and other sources of previous care than under normal conditions

2. Two to five years: temperamental characteristics, general course of development, any special problems

3. Five to ten years: coordination skills, visual-perceptual abilities, comparability to age-mates, special problems, special abilities

4. Adolescence:

   (a) Physical changes: secondary sexual characteristics, age at menarche, any subjective concerns

   (b) Behavior and attitude: quality of relationships with family members, with friends, with persons in authority; changes in personality traits and temperament affecting relationships; communication skills or problems

5. School achievement:

   (a) Academic: general attitude, level of responsibility, best-liked subject, least-liked subject, failures, honors, educational aims

   (b) Athletic: participant enjoyment, spectator enjoyment

E. Social

1. Body image: satisfactory, unsatisfactory, ambivalent, hopeful

2. Self image: comparability to peers, to siblings, to parents; degree of anxiety or depression (sleep problems, eating or stomach problems, facial expression, voice quality, responsiveness); level of self-confidence

3. Mood swings: distractibility, predictability, excessive depth or duration of mood changes, evidence of suicidal thoughts or attempts

4. Interests:
   (a) Vocational: degree of choice, of certainty, of practicability
   (b) Recreational: usually solitary, usually group, mixed

5. Family: group activities, special alliances, special enmities; locus of strength and stability

6. Peers: number, variety, and intensity of friendships, ease in relating and sharing, capacity for sympathy and loyalty, tendency to exploit or to be exploited, companionability

7. Sexual: dating, sexual experience, ideas about marriage and family, apparent knowledge, history of abortions, or parenting

8. Coping with stress: characteristic patterns (active, passive, projecting, avoiding); use of aids (smoking, alcohol, drugs, etc.); degree of awareness

F. **Staff Note:** Refer to second paragraph on page 11

CHAPTER IV

THE PHYSICAL EXAMINATION

Undergoing a physical examination is not necessarily a pleasant experience. Some anxiety and discomfort are generally involved, and the very process of being "examined" can make the patient feel like an object to be manipulated and explored. For adolescents whose sense of self is so especially delicate, it can be nothing short of intrusive in its scrutiny of bodily orifices. Every possible step must be taken, therefore, to lessen its unpleasantness, and several such steps deserve mention.

Staff

Optimally, the examiner will be of the same sex as the adolescent — a man for boys, a woman for girls (today's sexual freedom within age groups is not matched by equal freedom between age groups where the dominance-submission issue becomes very touchy). When this condition cannot be met it should be openly acknowledged and regretted, to convey the examiner's regard for the adolescent's feelings. The presence of a third person during the examination is a recommended procedure, preferably a staff assistant competent to record findings as the examiner dictates them. When no assistant is available, and the young person has come alone or prefers not to have a companion present, it may be well to limit the examination to the items not requiring the patient to undress if the patient seems uncomfortable about nudity.

For every procedure the examiner should give explanation in advance, and results, when determined, in a straightforward and courteous manner. Under these circumstances most youngsters will be likely to accept routine examining procedures.

Arrangements

Enough privacy should be assured to preclude overhearing; and full privacy, including covering sheet, should be provided for any examination

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of the unclothed body. It is generally helpful to show the adolescent any instruments to be used while explaining how and why they are used. The patient should be left alone to undress and to dress again unless some handicap necessitates help. It should be remembered that the adolescent has the right to refuse procedures at any time, but refusals are not likely to occur if the examiner has been duly considerate of the patient's well being.

Order of Procedures

The sample basic chart on page 19 can serve as an adequate record of findings and also suggests the recommended order of procedures. Page 20 is a growth chart on which to record both height and weight, and pages 22 through 25 provide graphs for recording percentile ranks, by sex, for height-by-age and weight-by-age, along with instructions for graphing, and guidelines for interpretation. (weight-for-stature charts are not included, since their percentiles vary with age at onset of puberty, which in turn varies by individuals.) Most teenagers, although they may not ask, will be interested to know their percentile ranks on these measures and it is worth taking an extra few seconds to give them the appropriate reassurance or advice.

Item 25 on the sample basic chart is defined by tables on page 26. As suggested by Tanner's Charts, page 27, developmental events occur in a fixed sequence although the total time involved varies not only by sex but between individuals. Young people easily grow anxious if they think they are significantly different from normal in sexual development. Some anxiety should probably be assumed even if it is not evident in facial or verbal expression. Here, again, the best reassurance is a simple, straightforward report of the findings in the context of normal variations and timing. In short, the physical examination, like the health history, should be not only a first screening instrument, but also a brief course in health education, and a step toward health maintenance.

SAMPLE PHYSICAL EXAMINATION RECORD

Age ___ Height (cm/inches) _____ Weight (kg/lbs) ___ B.P. _____
Percentile Percentile

Elements of a basic examination	Norm.	Abn.	Not Exam.	
1. General Appearance				
2. Nutrition				
3. Posture, Gait				
4. Vocalization, Speech				
5. Skin				
6. Head				
7. Ears				
8. Eyes (include fundi)				
9. Nose, Mouth, Pharynx				
10. Teeth				
11. Neck (include thyroid)				
12. Lymphatics				
13. Chest				
14. Breasts				
15. Heart				
16. Lungs				
17. Abdomen				
18. External genitalia				
19. Hernia				
20. Skeletal (include back - scoliosis)				
21. Extremities (include pulses)				
22. Neurological				
23. Pelvic				
24. Rectal				
25. Stage of maturity				1 2 3 4 5

(Circle appropriate no. from chart page 26)

ABNORMALITIES FOUND

IMPRESSION

CARE PLAN

HEALTH EDUCATION NEEDS

DISPOSITION (When all referrals completed)

Examiner's Signature _____

Date _____

Physician's Signature _____

Date _____

SAMPLE GROWTH CHART

Stature for Age

Weight for Age

NAME _____ RECORD _____

DATE OF BIRTH _____

Date of Measurement	Age Years	Months	Stature	Weight	Comments

These charts to record the growth of the individual child were constructed by the National Center for Health Statistics in collaboration with the Center for Disease Control. The charts are based on data from national probability samples representative of girls in the general U.S. population. Their use will direct attention to unusual body size which may be due to disease or poor nutrition.

Measuring: Take all measurements with the child in minimal indoor clothing and without shoes. Measure stature with the child standing. Use a beam balance to measure weight.

Recording: First take all measurements and record them on this front page. Then graph each measurement on the appropriate chart. Find the child's age on the horizontal scale; then follow a vertical line from that point to the horizontal level of the child's measurement (stature or weight). Where the two lines intersect, make a cross mark with a pencil. In graphing weight for stature, place the cross mark directly above the child's stature at the horizontal level of her weight. When the child is measured again, join the new set of cross marks to the previous set by straight lines.

Do not use the weight for stature chart for girls who have begun to develop secondary sex characteristics.

Interpreting: Many factors influence growth. Therefore, growth data cannot be used alone to diagnose disease, but they do allow you to identify some unusual children.

Each chart contains a series of curved lines numbered to show selected percentiles. These refer to the rank of a measure in a group of 100. Thus, when a cross mark is on the 95th percentile line of weight for age it means that only five children among 100 of the corresponding age and sex have weights greater than that recorded.

Inspect the set of cross marks you have just made. If any are particularly high or low (for example, above the 95th percentile or below the 5th percentile), you may want to refer the child to a physician. *Compare* the most recent set of cross marks with earlier sets for the same child. If she has changed rapidly in percentile levels, you may want to refer her to a physician. Rapid changes are less likely to be significant when they occur within the range from the 25th to the 75th percentile.

In normal teenagers, the age at onset of puberty varies. Rises occur in percentile levels if puberty is late.

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HEALTH RESOURCES ADMINISTRATION, NATIONAL CENTER FOR HEALTH STATISTICS,
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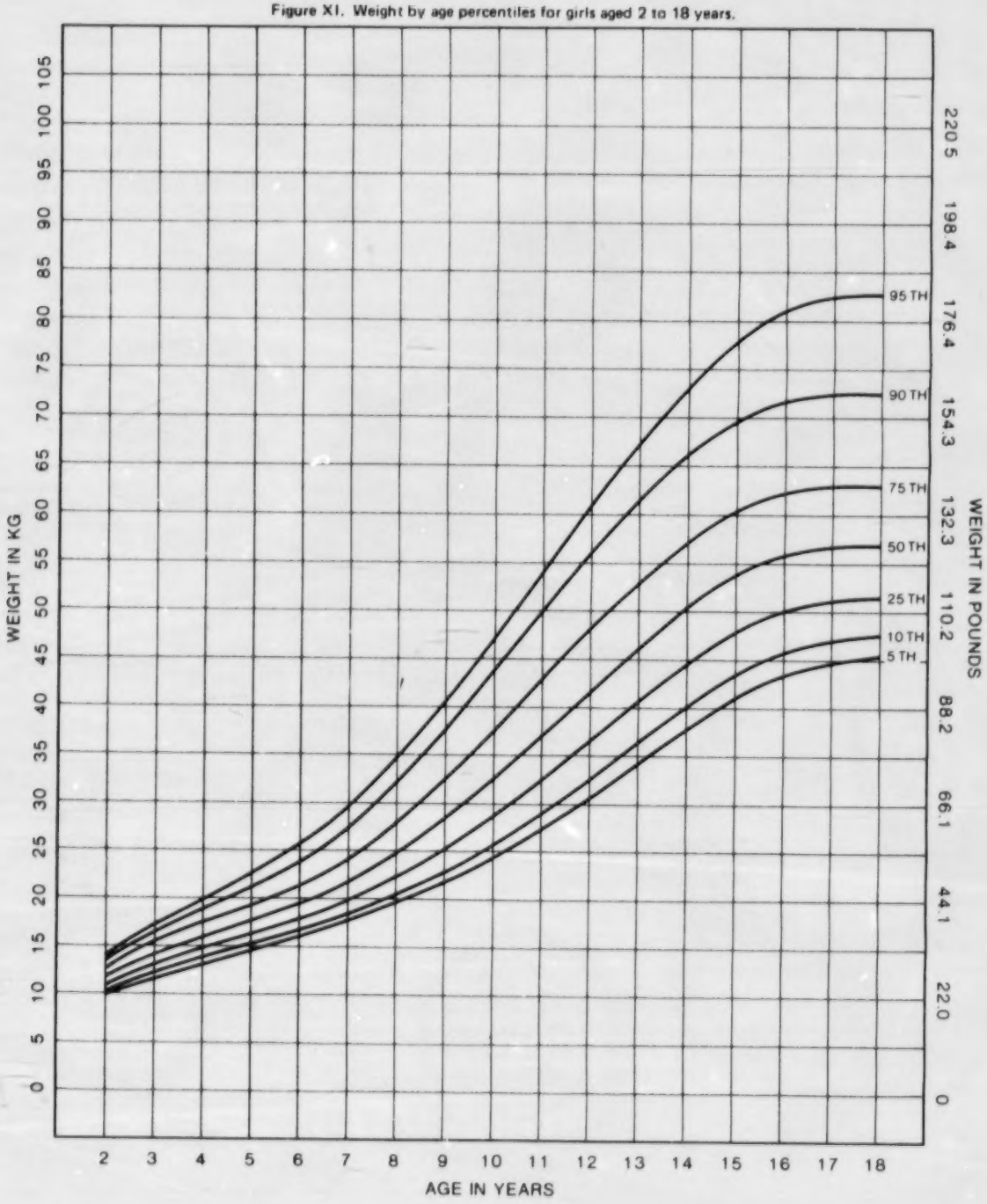
NATIONAL CENTER FOR HEALTH STATISTICS

Figure XI. Weight by age percentiles for girls aged 2 to 18 years.



NATIONAL CENTER FOR HEALTH STATISTICS

Figure IX. Stature by age percentiles for girls aged 2 to 18 years.

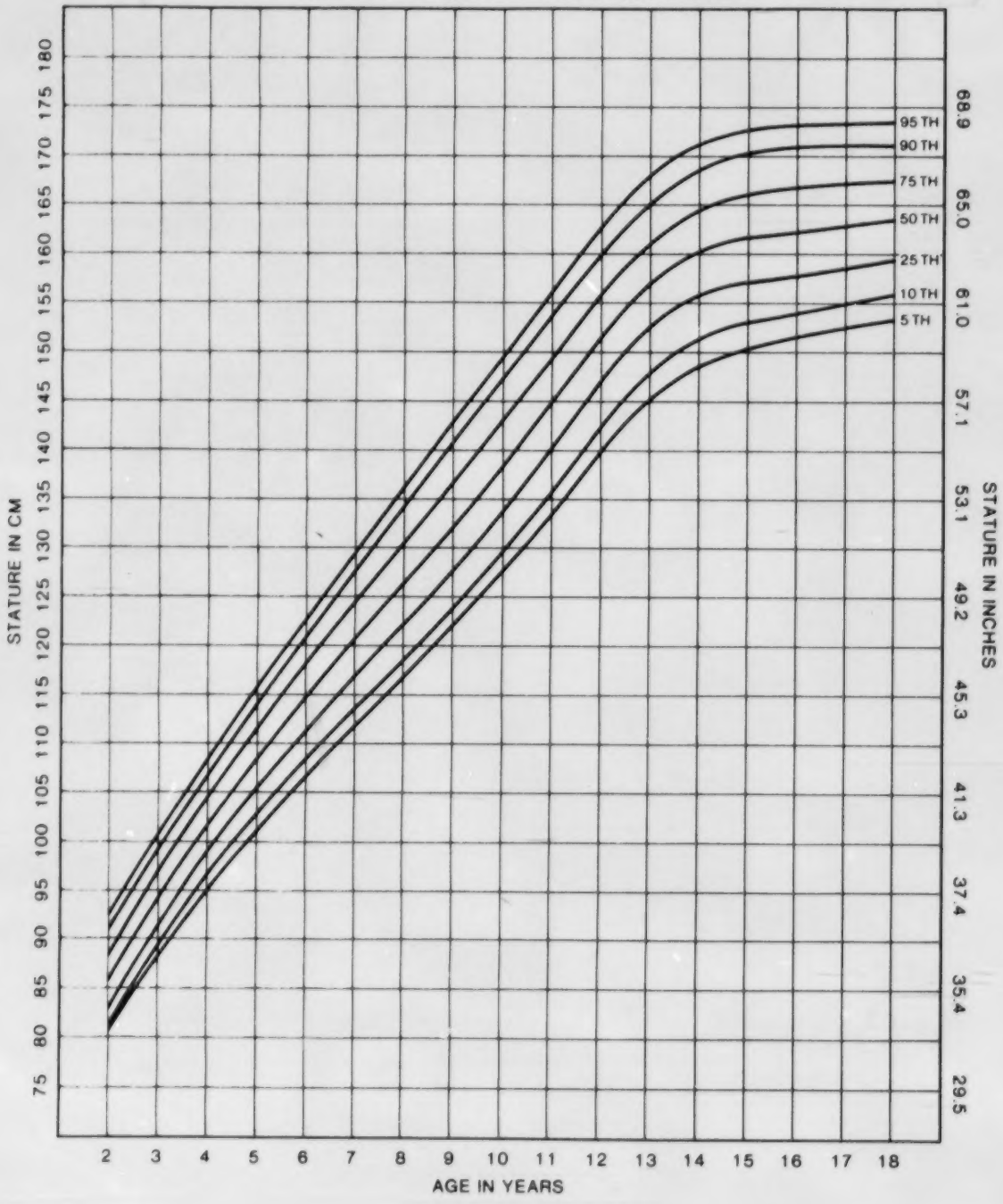


Figure XII. Weight by age percentiles for boys aged 2 to 18 years.

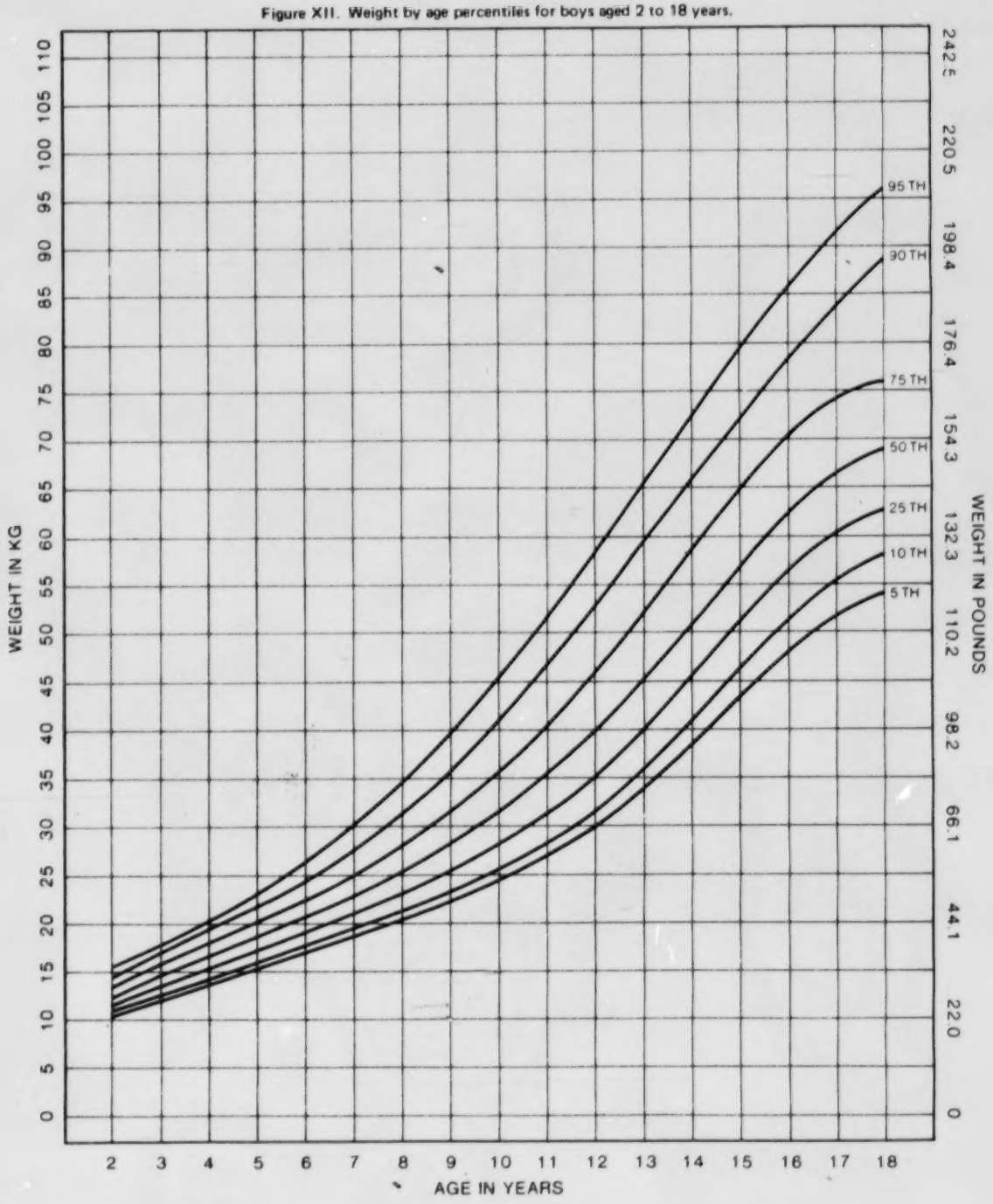
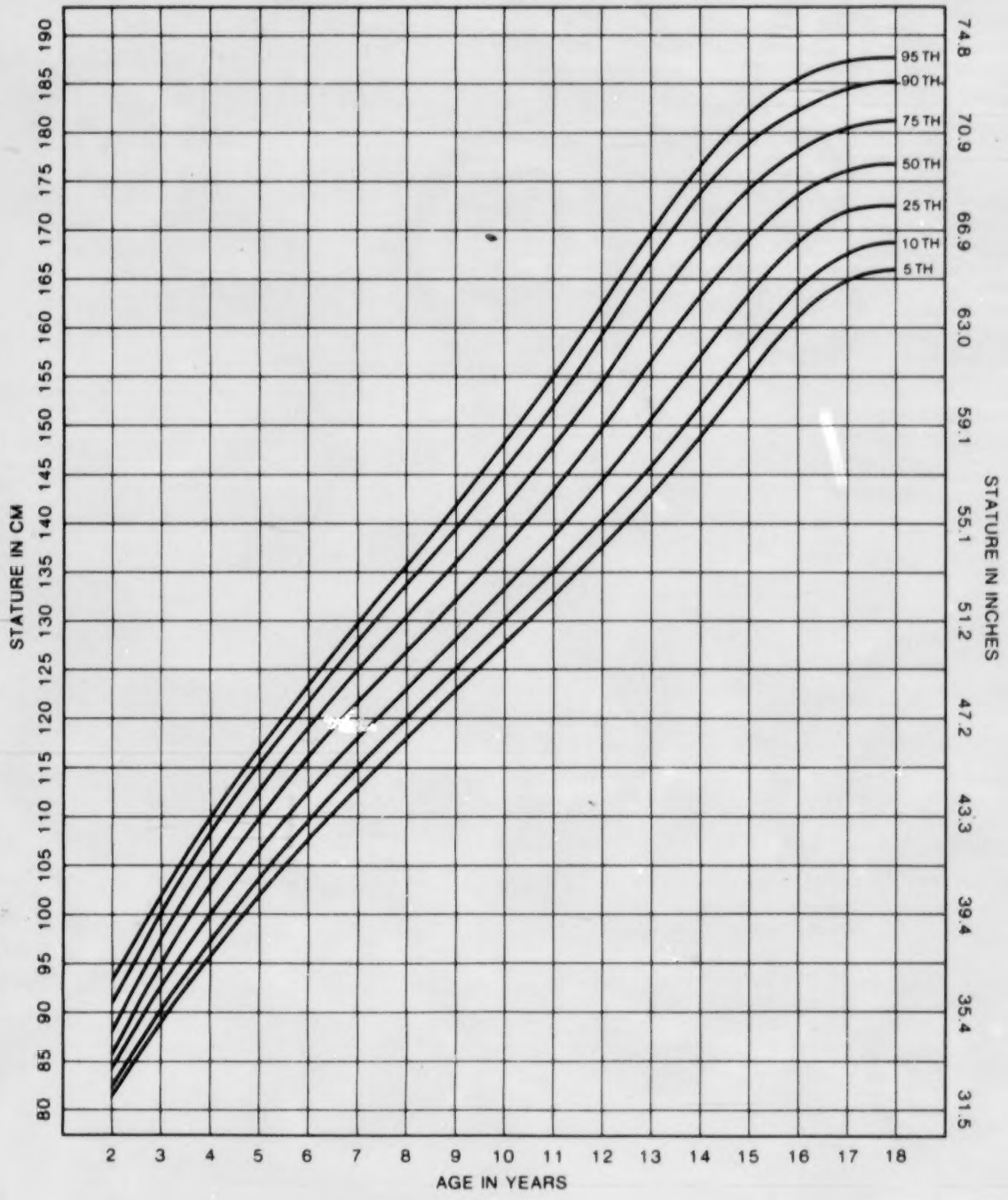


Figure X. Stature by age percentiles for boys aged 2 to 18 years.



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CLASSIFICATION OF GENITALIA MATURITY STAGES
by Sex*

In Girls

Stage	pubic hair	Breasts
1	Preadolescent	Preadolescent
2	Sparse, lightly pigmented, straight, medial border of labia	Breast and papilla elevated as small mound; areolar diameter increased
3	Darker, beginning to curl, increased amount	Breast and areola enlarged, no contour separation
4	Coarse, curly, abundant but amount less than in adult	Areola and papilla form secondary mound
5	Adult feminine triangle, spread to medial surface of thigh	Areola now in same contour as breast

In Boys

Stage	pubic hair	Penis	Testes
1	None	Preadolescent	
2	Slight, long, slightly pigmented	Slight enlargement	Enlarged scrotum, pink texture altered
3	Darker, starts to curl, small amount	Penis longer	Larger
4	Resembles adult type, but less in quantity, coarse, curly	Larger, glans and breadth increase in size	Larger, scrotum dark
	Adult distributions spread to medial surface of thighs	Adult	Adult

*Tanner, adapted from "The Adolescent Patient" by William A. Daniel, Jr., M.D.

Diagram of sequence of growth in boys and girls at adolescence - Tanner (From: "The Adolescent Patient" by William A. Daniel, Jr., M.D.)

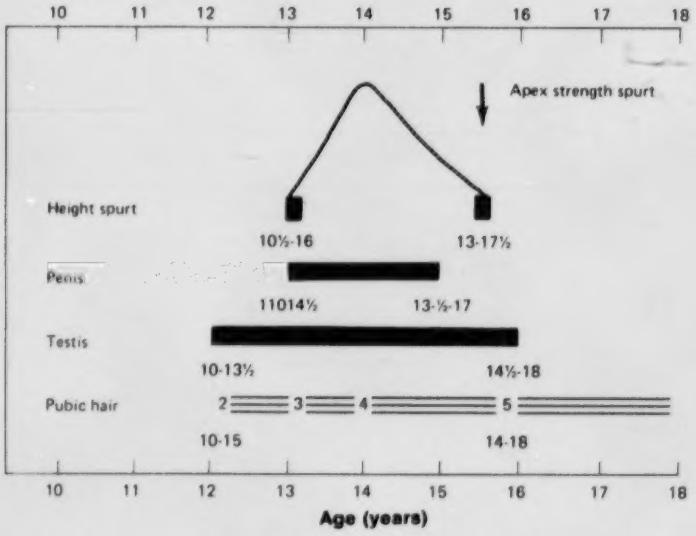

Diagram of sequence of growth in boys at adolescence. An average boy is represented. The range of ages within which each event charted may begin and end is given by the figures placed directly below its start and finish. (From Tanner, J.M.: Growth at adolescence, ed. 2, Oxford, England, 1962, Blackwell Scientific Publications, Ltd.)

. Diagram of sequence of growth in girls at adolescence. An average girl is represented. The range of ages within which some of the events may occur is given by the figures placed directly below them. (From Tanner, J.M.: Growth at adolescence, ed. 2, Oxford, England, 1962, Blackwell Scientific Publications, Ltd.)

CHAPTER V

SCREENING PROCEDURES AND REFERRAL FOR DIAGNOSIS AND TREATMENT

Screening for physical problems (illness) is an attempt to ascertain by relatively quick and reasonably reliable methods (1) if typical symptoms of a certain disease are present, (2) if usual prodromal signs of the disease are present, or (3) if conditions exist that put the subject at risk. It is never in itself a diagnosis but merely an arrow (or two or three arrows depending upon the degree of urgency involved) pointing toward the need either for continued monitoring through screening or for referral for diagnosis and any indicated treatment. Judiciously used, screening can facilitate early case-finding (i.e., earlier diagnosis), and therefore treatment in time to prevent handicapping sequelae. Its broader potential is the amelioration, even the elimination, of the conditions that invite disease, and the promotion of the conditions that support and maintain health.

By definition[4] screening procedures are imperfect, and therefore should be repeated periodically, both to pick up cases missed on earlier screening, and to find those developing between screenings. The periodicity for screening, however, if not yet clear-cut. The chart on page 46 adapted from the American Academy of Pediatrics "Recommendations for Preventive Health Care,"[5] outlines one possible approach.

It should be noted that since screening is the first phase and an integral part of comprehensive health care, it is subject to the same regulations for informed consent as other medical procedures.

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4. For further details see "About Screening," Lorene A. Stringer, DHEW Publication No. (ADM) 74-115, Washington, D.C.
5. "Standards of Child Health Care," American Academy of Pediatrics, 3rd Edition, 1977, Evanston, Illinois, pp. 13-14.

Immunization Review

To determine whether or not a given adolescent needs additional immunization, the following chart may serve as a guideline:

*Immunization Schedule**

Age	Vaccine
2 months	Diphtheria-Tetanus-Pertussis (DTP) plus Trivalent Oral Polio Vaccine (TOPV)
4 months	DTP + TOPV
6 months	DTP + TOPV
1 year	DTP + TOPV plus Measles, Rubella, plus Mumps
1½ years	DTP + TOPV
4-6 years	DTP + TOPV
14-16 years	TD (adult tetanus-diphtheria vaccine) and thereafter every 10 years

*Report of the Committee on Infectious Diseases, American Academy of Pediatrics, 1974, Table 1, p. 3.

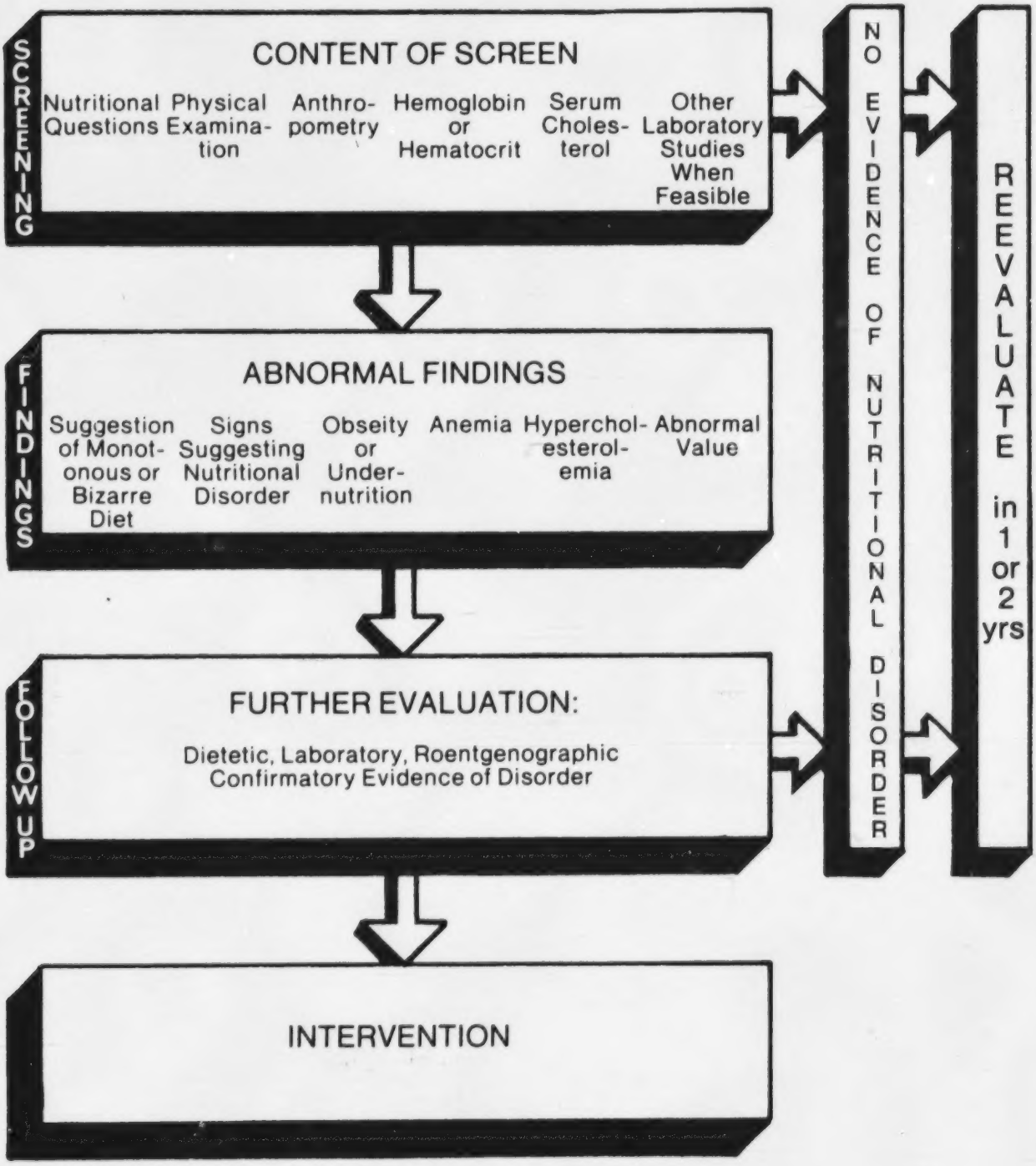
It is never necessary to restart an incomplete series. Immunizations should be resumed where they are interrupted. Thus, an adolescent of 16 years who has completed all of the above immunizations will need only an adult tetanus-diptheria booster.

Immunizations are all too frequently absent or incomplete, and this lack of preventive care can have very serious consequences. When an adolescent has never received immunizations, a series of 3 DT + TOPV is needed, plus rubella, measles, and mumps vaccine. However, rubella vaccine should not be given to a post-menarchal girl until (a) it is determined that she is not pregnant, (b) adequate precautions are taken to ensure that she does not become pregnant within the following three months, and (c) serological testing (rubella titer determination) shows her lacking immunity to rubella.

Nutritional Status Evaluation

The chart on page 30 summarizes the nutritional status evaluation. Screening procedures should identify adolescents who are (1) undernour-

NUTRITIONAL SCREENING AND ASSESSMENT PROCESS



ished, malnourished, or overnourished, (2) who may have iron-deficiency anemia, or (3) whose serum cholesterol level is abnormally high. A number of items in both the Introductory Health Questionnaire and the Health History (pp. 11-16) relate to nutrition, and these should be referred to in beginning this evaluation for the clues they can yield to dietary habits. It is well to recognize, however, that few things are more difficult to change than the dietary habits of adolescents being determined as they are, not only by cultural and economic factors, but also and even more strongly by the influence of the peer group. It is usually wise to refrain from advice or comment beyond reporting measurements until the screening procedures have been completed.

Anthropometric Evaluation

Appropriate-size beam or balance scales with non-detachable weights should be used to measure weight, and the accuracy of the scales should be checked by calibrated weights at least every three months. Standard clothing requirements for weighing should be formulated and followed to ensure consistency.

To measure height a measuring stick or tape should be fixed to a true vertical flat surface. The adolescent should stand barefooted, with heels together and back as straight as possible, with heels, buttocks, and shoulders touching the wall. A block square at right angle to the wall is then brought to the crown of the head and the measurement noted.

With date of birth and date of examination, weight and height data can then be transferred to the appropriate growth charts (see pp. 22-25). Adolescents with weight-for-age less than the 5th percentile, or greater than the 95th percentile, or with height-for-age less than the 4th percentile, should be referred for further evaluation.

Hemoglobin and Hematocrit Estimation

An increasing incidence of iron-deficiency anemia has been found in adolescents, presumably due to the combination of poor diet and rapid growth. In a ten-State nutrition survey it was found that essentially all anemias were of the iron-deficiency type and that the prevalence was higher in adolescent males for those from low-income families than in those from higher-income families (although that relationship did not hold for adolescent females).

*Hemotologic Values During Adolescence**

Age	Hemoglobin Gm./100 ml. % Mean	Hemoglobin Gm./100 ml. % Range	Hematocrit % Mean	Hematocrit % Range
7-12 yrs.	13.0	11.0-16.0	38	34-40
Adult				
Female	14	12.0-16.0	42	37-47
Male	16	14.0-18.0	47	42-52

*Adapted from the Textbook of Pediatrics, Nelson, Vaughan, McKay Table 14-3, p. 1043.

Adolescents with hemoglobin level less than 11.0 gm. per 100 ml., or with hematocrit level less than 34%, should be referred for further study, including:

- Detailed history of nutrition, blood loss, parasitic infections, other infections
- Full blood count and indices
- Stool examination for occult blood
- Hemoglobin electrophoresis if the sickle cell dex is + in a black child
- Serum iron determination

Since the screening levels for interpretation of hemoglobin and hematocrit values have been arbitrarily chosen, they may require local review. In a large screening program it is often feasible to collect and examine blood samples at some central location equipped with electronic counters that are both accurate and inexpensive (e.g., a government or commercial laboratory or a local hospital) and this might permit determination of local means and ranges different from those given in the above table on this page.

Serum Cholesterol Estimation

All adolescents with known heart disease in the family, especially where there have been cardiac deaths in related young adults, should have a cholesterol estimation. A serum cholesterol concentration between 200 and 230 mg per 100 ml, if verified by a second determination, indicates need for close monitoring and dietary supervision. A serum cholesterol concentration greater than 230 mg/100 ml (again verified by a second determination) is distinctly abnormal and an indication for immediate

referral for study and treatment of the adolescent subject and, if possible, for screening of the family members as well.

Anorexia Nervosa

Although anorexia nervosa is (fortunately) a relative rare condition, it occurs often enough in adolescent girls to require at least a passing note. When undereating is accompanied by progressive weight loss; symptoms of severe anxiety, depression or profound self-preoccupation, and apathy to all external stimuli; then anorexia nervosa should be suspected, and referral for full evaluation made at once. If the condition is not promptly and correctly diagnosed and treated, it terminates in early death—suicide by starvation. Treatment must be both medical and psychiatric to be effective.

Summary

If an adolescent presents no hint of nutritional disorder on the basis of these various screening approaches, no more is needed than a passing positive comment, a reminder to return within 12 to 24 months, or earlier if needed, for a repeat screening and whatever brief recommendations seem indicated. In the interest of health education, it is a good idea to have a supply of printed material on the basics of good nutrition so that each young person can take home a copy for occasional reference.

If a question of some nutritional disorder arises from any of the screening approaches, referral should be made for diagnostic evaluation and any indicated treatment, including intensive nutritional counseling and supervision. It is worth noting that the problems of both overeating and undereating are heavily involved with psychological factors and may require ancillary mental health treatment or, at least, mental health consultation. There is some evidence, however, that for obese adolescents, group counseling is more effective than individual counseling.

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Report of Inter-Society Commission for Heart Disease Resources, Guidelines for the Detection, Diagnosis, and Management of Hypertensive Populations. Inter-Society for Heart Disease Resources, 44 E. 23rd Street, Suite 316, New York, New York, 10010.
High Blood Pressure Control: A Guide for Community Programs, American Heart Association, 44 East 23rd Street, New York, New York, 10010.
"Dietary Treatment for Hyperlipidemias." American Heart Association.

Dental Care[6]

Most adolescents suffer with dental caries, and a significant number suffer inflammatory diseases of the supporting structures of the teeth. In addition, many are handicapped by severe malocclusion or extensive tooth loss. Because these disorders impair or threaten to impair personal attractiveness, young people are generally quite willing, even eager, to be fully cooperative in their treatment. By the same token, however, they are also quite anxious and need all the reassurance that can be given honestly.

Screening

Since virtually all of the eligible population will require dental services, dental screening should be undertaken only to assure access to dental care when the adolescent has not visited a dentist within a specified number of months. Dental screening should amount to referral for dental evaluation and treatment for any adolescent not already under regular dental care.

6. See "Guide to Dental Care - EPSDT, Medicaid," prepared by the American Society of Dentistry for Children and the American Academy of Pedodontics, in cooperation with the Social and Rehabilitation Service, HEW, 1975.

Diagnosis and Treatment[7]

Services necessary for the preservation of the dentition and supporting structures should be provided through age 21. Diagnostic and treatment services should be linked together, both being the responsibility of legally qualified dental practitioners and their auxiliary personnel. (The role of auxiliaries is defined by the Dental Practice Act of each State. These Practice Acts have been changed in a number of States and are in the process of change in others to encourage the delegation of additional duties to trained dental auxiliaries as a means of extending oral health services to more children who need them.)

Radiographic surveys are undertaken to detect anomalies and disease and to evaluate development. Between age seven and age thirteen, a new patient will usually receive two cavity-detecting (bite wing) and ten peripical radiographs, or the equivalent (such as a panographic survey). Above the age of thirteen, the radiographic survey includes four cavity-detecting and fourteen peripical radiographs or the equivalent. Adequate protection, particularly of the gonadal and thyroid areas, should be provided during dental x-rays. Routine full-month x-rays should be limited to two exposures, one between seven and thirteen years of age, and one after age thirteen. Any additional x-rays should be based on specific needs for radiological information.

Oral prophylaxis and the topical application of fluorides should be provided at least annually and, optimally, twice a year. When fluorides are not available through the community water supply, they should be given by prescription.

Summary

Comprehensive dental services should include (a) emergency services, (b) therapeutic services for dental disease that if left untreated might become acute dental problems or might cause irreversible damage to the teeth or supporting structures, and (c) preventive services including patient or patient-and-parent education. If limited resources make it necessary to establish priorities for oral health, these should be determined jointly by the director of dental services and the appropriate EPSDT program official, and should be subject to periodic review and modification.

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7. The treatment of deformities caused by oral clefts, burns, trauma, etc., are currently provided in most States by specialized agencies (e.g., Crippled Children's Services).

Vision

It is estimated that 25% of school-age children have some form of eye problem, over three-fourths of them being refractive errors, the remainder being muscle imbalance, amblyopia, or color vision defects. The purpose of vision screening is to identify those children and to refer them for diagnosis and treatment.

Vision screening is done routinely in many schools, usually on a two-year basis in the elementary grades, and many children who have eye problems are thus identified early. However, there remain significant numbers of adolescents who have never been screened for vision defects. It is also possible for new eye problems to develop at any time. Therefore vision-screening is an integral part of any EPSDT program for adolescents.

The Snellen chart is the simplest and least expensive means for testing central visual acuity under standard conditions. The chart should be placed on a light and uncluttered wall, well-illuminated, and with the chart so fastened that the 20-foot line is at eye-level. A rating of 20/30 or less is abnormal, and, confirmed by a second rating, is cause for referral for diagnosis and treatment.

Such special instruments as the Titmus Vision Screener (initial cost about $500) can test for acuity, accommodative ability, muscle balance, and color vision. These instruments are accurate and convenient. The testing takes only a few minutes and can be done by a trained technician.

Any screening procedure that yields an abnormal finding should be repeated. Even where screening detects no abnormality, an adolescent with symptoms of an eye problem should be referred for diagnosis. Classroom teachers are sometimes astute observers of their students and may notice signs of vision difficulty even before the student is conscious of it. In some cases, therefore, it is worthwhile to consult classroom teachers about suspected eye-problems, as well as to enlist their help in the follow-up of treatment procedures.

Full diagnostic evaluation of vision includes (1) further evaluation of visual acuity, (2) lens tests for hyperopia, (3) muscle balance tests, (4) depth perception tests, and (5) color descrimination tests (required only once). When corrective glasses are prescribed, EPSDT mandates that glasses be provided. Careful follow-up is needed to ensure that the adolescent uses the glasses as prescribed. This is often an exceedingly difficult task, requiring utmost sensitivity and tact.

Hearing

Children with congenital or early severe hearing loss are usually identified well before adolescence as handicapped children in need of special education. (This is not to say that their handicap is always recognized as hearing loss; all too often they are thought to be mentally retarded.) The central aim of an adolescent screening program is to identify those hearing losses that come on so gradually and insidiously as often not to be recognized even by the adolescent concerned, or thought to be due to preoccupation or inattentiveness. The higher-frequency cochlear losses are included among these.

Screening procedures should be conducted under the supervision of an audiologist qualified according to the professional requirements of the American Speech and Hearing Association. Personnel conducting the tests should be trained in audiometry and in such general aspects of screening procedures as the protection of confidentiality. Audiometers should meet the ANSI S3.6-1969 requirements[8] and instruments should be calibrated at least once a year, preferably twice. The sound pressure output of each audiometer should be checked at least every three months in accordance with standard calibration procedures, and a daily check should be made by listening for normal and usual performance.

It is practically essential, at the present time, to conduct this kind of screening program in some central, specifically designed and unchanging location both to safeguard the calibration of the instruments and to achieve an adequately quiet testing environment. (Noise in the testing room should not exceed 50 dB SPL at 100 Hz; 58 dB SPL at 2000 Hz; and 76 dB SPL at 4000 Hz using a sound level meter with octave bands centered on the hearing frequencies.)

The recommended frequencies to be tested with individual puretone air conduction audiometry range from 500 Hz (if the testing environment is very quiet) to 1000, 2000, 4000, 6000, and 8000 Hz. Recommended loudness levels are 20 dB up to 2000 Hz, and 25 dB at higher frequencies. Failure to respond at the recommended loudness levels, at any frequency in either ear, calls for rescreening, which may be done immediately by removing the earphone, repeating instructions, and then repositioning

8. American National Standards Institute, Inc., New York: American National Standards Specifications for Audiometer (ANSI S3.6-1969). American Standard Criteria for Background Noise in Audiometer Rooms (1960) (ANSI S3.1-1960). American Standard Specification for Audiometers for General Diagnostic Purposes (1951) (ANSI 2245-1951). Darley F. (ed) (1961) Identification Audiometry, J. Speech Hearing Disorders, Monograph Supplement No. 9. Eagles, E (1961) Hearing Levels in Children and Audiometer Performance, Appendix B in J. Speech Hearing Disorders. Monograph Supplement No. 9 (F. Darley, ed.) 5262. American Speech and Hearing Association. Guidelines for Identification Audiometry, Approved November 1974 by the American Speech and Hearing Association.

the earphone. It should be done within a week if it is to have valid relation to the initial screening.

If the rescreening confirms the failure, referral should be made, first to a physician (preferably an otologist, if one is available) for medical evaluation of the adolescent's health and the condition of the hearing mechanism, then to a qualified audiologist for complete audiological evaluation. The medical treatment should include not only therapy for any acute or chronic disease that is present, but also recommendations for the prevention of ear diseases.

Audiological evaluation should include threshold measurements for both air and bond construction (and impedance measurements when appropriate), speech audiometry, and an assessment of the adolescent's communicative abilities. Audiological treatment should include all possible aural rehabilitation, provision of a hearing aid when indicated, and such educational and social-psychological services as may be needed to restore the young person to optimal functioning within the limits imposed by the handicap. The importance of these additional services can hardly be overstated. Any significant hearing loss is a seriously isolating condition that can lead to severe social impairment unless strenuous and continuing efforts can be mobilized to develop compensating mechanism and skills.

Speech

Deviations in speech are significant where they attract adverse attention, interfere with communication, threaten the health of the vocal structures, or make the speaker feel anxiously self-conscious. The adolescent's degree of ability to communicate with the health professional during the history and examination process will provide valuable clues to most, if not all, of those conditions provided the professional has at least a basic orientation to speech pathology.

The grosser speech deficiencies are usually identified before the adolescent years and optimally referred for therapy. Old problems are sometimes exacerbated by the stress of rapid physical growth and change and new problems sometimes develop as a result of maturing pitch changes, vocal abuse, or an increasing handicap from hearing impairment. The problems about which an adolescent may be highly sensitive and want help are stuttering, a tendency to lisp, and at least in boys, a high-pitched voice. Referral for any of these is likely to be acted upon by the adolescent.

The analysis of language, although highly related to analysis of speech, takes into account the content and organization of thought, the effects of developmental age, and cultural environment. It is a complex process, not readily amenable to screening except by specialized professionals. For more detail, see the section on Developmental Review (page 55).

Hypertension

Since anxiety tends to elevate blood pressure, any high reading should be checked by a second reading after an interval long enough or reassuring enough to allay the anxiety. The method of taking the blood pressure should be standardized and there should be a sufficient variety of cuffs to permit selection of a size that will cover two-thirds of the upper arm. If the second reading also is high, inquiry should be made about any drugs the adolescent may be taking (whether by prescription or otherwise obtained). Amphetamines and birth-control pills are common contributors to hypertension in adolescents and again, as part of their health education, it is important for young people to know that drugs, anxiety, and other kinds of stress may affect blood pressure. It is often helpful, if they seem very insecure, to teach them how to use and read the sphymomanometer themselves.

Interpretation of findings is more difficult, since absolute standards and definitions of hypertension have not been firmly established for adolescent age groups. A number of studies,[9] however, suggest that readings of brachial artery cuff blood pressures above the following levels should be considered abnormal:

Normal Blood Pressure Readings, by Age

Sex	Age	Diastolic Pressure	Systolic Pressure
Female	10-13 years	≤80	≤140
Female	13-15 years	≤85	≤140
Male	10-15 years	≤80	≤140

9. This chart was included as part of a package on pediatric hypertension developed by Ellin Lieberman, M.D., Renal Division, Children's Hospital of Los Angeles, presented at the October 1974 meeting of the American Academy of Pediatrics at San Francisco. Other helpful references include: "Essential Hypertension in Children and Youth, A Pediatric Perspective," Ellin Lieberman, M.D. *Journal of Pediatrics*, July 1974, Vol. 85.1; and "Blood Pressure Standards for Normal Children as Determined Under Office Conditions." Sol Londe, M.D., *Clinical Pediatrics*, July, 1968. Vol. 7.

Adolescents with elevated level should be referred for diagnosis and treatment even if they are otherwise symptom-free. Unusually low readings should be noted and marked for follow-up monitoring.

Urinalysis and Bacterial Count

A routine urinalysis should be done for each adolescent entering the screening program. A "clean catch" specimen is necessary but the dipstick method of testing for glucose and albumin is acceptable. In some instances it will be desirable to test also for ketone bodies and urobilinogen. The microscopic examination requires centrifuging 5-10 cc of urine for 3 to 5 minutes, and examining the sediment. Normally there should be less than 3 RBC's, 5 WBC's and 1 cast per high-powered field.

Since positive findings suggest diabetes mellitus or kidney disease, they should always be checked. If repeat positives are obtained under standard conditions, referral for diagnosis and treatment should follow at once.

For all adolescent girls some form of bacterial count should be obtained to check for urinary tract infections even though no symptoms are present. Because such infections can cause permanent renal damage, and because the estimated prevalence in girls ranges from 1% to 20%, the aim of screening is to identify the individuals with high counts, so that they can be referred promptly for antibiotic treatment and follow-up. In an otherwise symptom-free girl a count of 100,000 or more colonies per milliliter in three consecutive cultures is grounds for referral. If symptoms are present, a count of over 50,000 in two consecutive cultures is enough.

When laboratory tests are involved and the findings are not immediately available, the adolescent should be told the reasons for the test and the functions of health maintenance that the urine serves. A minute or two of clear explanation, preferably before giving instructions about how to obtain a clean specimen, will add appreciably to the girl's sense of security.

Tuberculin Sensitivity

Poverty and crowded housing conditions contribute significantly to the risk of incurring tuberculosis. It is, therefore, important that all EPSDT adolescents be tested once for tuberculin-sensitivity and be fully informed about the need for retesting after any exposure to a case of active tuberculosis.

A number of tests are available. The multiple puncture tests (Tine, Heaf, Monovac) require only simple skills to administer and to read and are generally used for the initial screening. Individuals showing doubtful or positive reactions to these tests, however, should be retested by the more precise Mantoux technique[10] which requires skillful intradermal injection of the antigen. They should also be evaluated by a clinician, the evaluation to include careful investigation of possible sources of exposure, medical history, physical examination, chest x-ray, and urinalysis.

All young people with positive Mantoux reactions should receive a prophylactic course of antituberculosis medication and those with clinical or radiological signs of the disease are candidates for treatment with more than one drug. All should be thoroughly briefed as to their health care.

Lead

Mass screening of adolescents for lead toxicity is unnecessary but screening and follow-up services should be offered to anyone suspected of having been unduly exposed to lead (e.g., living in the vicinity of a lead smelter or other industrial lead source). Those found with an elevated erythocyte protoporphyrin (greater than or equal to 50 micrograms per deciliter of whole blood) and an elevated blood lead (greater than or equal to 30 micrograms per deciliter) require a medical evaluation, environmental epidemiologic services, and periodic re-evaluation.[11]

Screening for Cancer (By Papanicolaou Smear)

While cancer is seldom found in adolescents, early detection is important to successful treatment. For one type of cancer, detection is easily achieved by the Papanicolaou (Pap) test. This kind of screening should be made available to all girls over the age of 16. There are no comparable screening techniques for other types of cancer. It is important to explain the procedure in advance, to cite the rarity of positive findings, and to mention the probable length of time before the results are known.

In Family Planning Clinics and in Maternal and Child Health Clinics, Pap tests and pelvic examinations are usually routine and some girls will already have been screened in one or the other such clinic. Others may

10. "The Tuberculin Skin Test." Supplement to "Diagnostic Standards and Classification of Tuberculosis and Other Mycobacterial Diseases." American Lung Association, 1974.

11. For further information, contact the Center for Disease Control, Environmental Health Services Division, Atlanta, Georgia, 30333.

need to be referred to these facilities. Where these resources are not available, the EPSDT program should offer screening and follow-up services. They are particularly indicated for girls who are taking oral contraceptives, using intrauterine devices, or who have been pregnant (the risk of cancer increases with higher parity). Also susceptible are girls who are known to have been exposed in utero to diethylstilbesterol (DES), and those known to be sexually active (especially those who began sexual activity at an early age and who have had a number of different sexual partners).

Screening for Venereal Disease

Venereal disease is widespread among young people and often is initially asymptomatic. For these reasons adolescents at risk should be routinely screened with but two exceptions. First, in accordance with Section 1907 of the Social Security Act, no person eligible for services under Title XIX may be compelled to undergo any screening, diagnosis, or treatment if the person (or in the case of a child, the parent or guardian) objects to such services. Second, unless State law or the ruling of the State Attorney General or other appropriate official permits adolescents to obtain medical services without parental knowledge or consent, the consent of parent or guardian should be obtained before screening.

Every female over the age of 16 who has a pelvic examination for any reason, including family planning, should have a cervical culture test for gonorrhea if no such test was done in the preceding six months. Whenever the sexual history indicates exposure to infection or there is reason to suspect it, a pelvic examination should be done specifically to obtain a cervical culture (a vaginal culture may serve). For males, a urethral culture should be obtained. Recent studies suggest that for both sexes, under certain circumstances, culture of the rectum and oro-pharynx may be effective in case-finding. If there is a vaginal or urethral discharge, examination of a gram stain smear can help in making a differential diagnosis.

Media that support the growth of the gonococcus while suppressing the growth of other bacteria should be selected. A number are available, such as the modified Thayer-Martin. Media for transportation should be provided if the culture cannot be plated immediately.

When the screening test is positive, the adolescent will need full explanation and as much reassurance as may be consistent with the need for treatment. Wherever possible, diagnosis and treatment should immediately follow screening.

If referral to another qualified resource for treatment is necessary, every effort should be made to facilitate the transition and ensure that treatment is actually given. The adolescent should be told about the need for testing contacts and asked to help in this way to protect sexual partners. Such follow-up of contacts may be most efficiently carried out by local health authorities.

A serologic test for syphilis should be provided for every child and youth entering the EPSDT system for the first time to rule out congenital disease. It should be repeated thereafter, for both males and females 16 years of age and older, as frequently as general examinations are given. Where there is a history of sexual contact, any suspicious genital or extra-genital lesion should be subjected to a dark field examination for spirochetes (Treponema Pallidum). If there is need for further assessment, as for example in cases of reinfection, the local health authority is usually equipped to perform tests of greater sensitivity.

For syphilis as for gonorrhea, treatment is best given immediately whenever that is possible. If a referral must be made, every effort should be made to ensure that treatment is actually given.

Informed Consent

The concept of informed consent requires that if there is a positive finding of venereal disease which is to be reported to public health authorities, the individual should be so informed in advance of the reporting, and the reporting should be consistent with that for other conditions. Utmost caution should be exercised to ensure that reporting involves no breach of confidentiality.

Screening for the RH Factor

Incompatibility in the RH blood factor between a pregnant female and her fetus occurs with significant frequency, especially among Caucasions. Fortunately, it is now possible to prevent Rh sensitization in an Rh-negative woman who has not yet developed antibodies to this blood factor.

It is essential to recognize that once a woman is sensitized the process is irreversible, and that the rest of her reproductive life is compromised. The serious implications of this crucial fact for nulliparous young girls, women under-going abortion, those who deliver, and for any infants they may subsequently have require preventive action. The Rh factor should, therefore, be determined in all adolescent girls who seek family planning, prenatal care or abortion.

The potential problem of Rh incompatibility should be fully explained to those who are Rh-negative, and plans made for the injection of the Rh immunoglobulin within 72 hours after the termination of pregnancy, whether by delivery or abortion.

Unless the fetus or newborn is definitely known to be Rh-negative, injection of the Rh immunogloblin should be routine in all unsensitized Rh-negative women.

Screening for Sickle Cell Trait and Disease

Sickle cell trait is not itself a disease. If both persons of a couple have a sickle cell trait, there is a 25% risk that any child they produce will have a sickle cell disease. We no not yet have any means of reducing that risk. Screening, therefore, is aimed primarily at finding the people who have the trait, so that they can be apprised of the risk and perhaps, through counseling, helped to choose deliberately among the options open to them.

The issue is delicate not only because it concerns marriage and reproduction, but also because it is heavily ethnic. Approximately 8% to 10% of American blacks have a sickle cell trait. It is also found in a very much lower percentage of people of Greek and Italian ancestry, and of Latin Americans from the coastal areas of the Caribbean and South America. Screening for hemoglobinopathies should be offered routinely for these "at risk" populations, preferably in early infancy, because if the disease is present, it can quickly become life-threatening. Since such screening has not been as widespread as it should have been and cannot be taken for granted, adolescents who are liable to the genetic trait but do not know whether or not they have it, should be offered hemoglobin electrophoresis. Only one test is needed, and it must be voluntarily taken. The findings should be promptly reported to the adolescent.

Because it is genetic and its symptoms are usually quick to appear, sickle cell disease is rarely diagnosed for the first time in adolescence. When that does occur, it is likely to be in conjunction with an anemia that does not respond to iron treatment. If feasible, an adolescent with the disease should be referred to a medical center for continuing and comprehensive care, assuming the consent and cooperation of the local physician.

When the screening test is positive for sickle cell trait, the health professional's obligation includes not only informing the adolescent and explaining its implications for the life-pattern, but also establishing a relationship that will open the way for further counseling as needed. It

should be made unequivocally clear that having the trait is not having a disease, that there will be no symptoms and no need to restrict activity except (and this at option) in relation to reproduction. In that respect the choices are limited. The young person may decide to:

(a) Avoid pregnancy through birth control,
(b) Terminate any pregnancy through abortion,
(c) Avoid marriage with anyone who also has the trait; or
(d) Take the 25% risk of having a child with sickle-cell disease.

Whatever their own convictions may be, health professionals should be willing and able to support the choice that the young person makes, not necessarily with agreement, but at least with sympathy and understanding.

It can be significantly helpful to have on hand some printed material on the subject for the adolescent to take home to read and think over.[12] If such material also bears the health professional's name and telephone number, it improves the likelihood of a follow-up contact for further consideration of germane issues.

Special Problems of Adolescence

Certain other disorders or exacerbations of disorders may occur in adolescence, presumably triggered by rapid growth spurts or by hormonal changes. Some may be identified through the screening procedures previously discussed. Some may be suggested by the health history or from observation.

Acne

This medically insignificant and usually self-limiting skin disorder should not be lightly dismissed. It is a source of acute narcissistic distress to those afflicted with it and everything that can be done to alleviate it should be done. Astringents, various salves, cleansing agents, peeling agents, and mechanical removal of comedos (blackheads) can bring a

12. This can be readily adapted from the "*Guidelines for Counseling Young Adults with Sickle Cell Trait*", which is available from the Job Corps, Manpower Administration, Dept. of Labor, Washington, D.C., and/or from "*A Guide to Screening—EPSDT/Medicaid,*" U.S. Dept. of Health, Education, and Welfare, Social and Rehabilitation Service in cooperation with The American Academy of Pediatrics, Washington, D.C. 1974.

degree of relief from the symptons, and to a significantly greater degree, put treatment into the adolescent's own hands. For more severse cases, cryoslush therapy, ultraviolet light, antibiotics, and steroid therapy are available.

Allergies

While many allergies manifest themselves in the form of hay-fever, asthma, or dermatitis, others may remain disguised as stomach disorders, frequent colds, unexplained edema, or unaccountable attacks of irritability or petulance. It is admittedly an onerous procedure to try to pinpoint allergens but if the symptoms appear to be increasing in frequency or severity, and particularly if a brief and carefully monitored trial of antihistamine therapy brings no improvement, then referral to an allergist is in order.

Suggested Periodicity for Screening

Screening	11-12 Yrs.	13-15 Yrs.	16-21 Yrs.
Health History	x	x	x
General Physical (Incl. Ht. + Wt.)	x	x	x
Immunization[a]			T.D.[a]
Nutritional Status	x	x	x
HCT./Hb	x	x	x
Serum Cholesterol[c]	x	x	x
Dental	x	x	x
Visual		x[a]	x[a]
Auditory		x[a]	x[a]
Blood Pressure	x	x	x
Urinalysis, BC[b]	x		
Tuberculin Sensitivity		x	
Pap Test			x
G.C.[a]			x[a]
Serology	x	x	x
Rubella Titer[d]	x[d]		
Rh Status	x		
HGB Electrophoresis	x		

a. Test may be performed earlier or more frequently if indicated. Make sure that immunizations are complete.

b. Bacterial count should be done once on girls during adolescence or on entering the EPSDT program, and thereafter if indicated.

c. Need not be done so often if initial value is in good range, and there are no other specific indications.

d. To be done once if not done previously.

Diabetes/Epilepsy

With both of these disorders, the problem in adolescence is not diagnosis, but treatment. Young patients whose illness has up to this point been well-controlled may fail to recognize that increasing body size usually requires increasing measures of control, and that failure to adjust their medications can lead to serious trouble. In addition, such chronic illnesses are a natural target for adolescent rebelliousness, and an otherwise unimaginative young patient may be tempted into challenging the diagnosis or treatment or both by dispensing with the treatment regimen. The health professional who is aware of these risks can sometimes prevent acute episodes by judicious and sympathetic counseling. Where this is not possible, it is important to recognize and deal supportively with the near-despair that follows the collision with reality.

Scoliosis

Adolescent girls should always be checked for any evidence of scoliosis. Where evidence is found, treatment should be instituted promptly, since the condition is more easily corrected in youth than at a later age. "More easily," however, is not equivalent to "easily," if a backbrace is required for even a few months. The appliance is not only uncomfortable and constricting, but it is also an embarrassment, and in the girl's eyes itself a deformity. Again, frank acknowledgement of the unpleasantness is called for. It is helpful to monitor the treatment often enough to note and report any improvement to the girl.

Thyroid Dysfunction

Girls are also more liable than boys to dysfunction of the thyroid gland. Hyperthyroidism is more commonly noted than hypothyroidism. Its symptoms are more conspicuous and, because its course may be more severe, its need for treatment is more compelling. However, it may subside gradually without treatment, whereas hypothyroidism is unlikely to normalize itself and, over time, can exert a subtly deleterious effect on the life-pattern.

Since accurate diagnostic techniques are readily available, they should be used whenever there is any evidence from observation or questioning of a possibly thyroid dysfunction. With or without treatment, the need for careful monitoring should be emphasized because the complicated psychosomatic interaction involved is capable of changing both the gland and the personality.

CHAPTER VI

Special Hazards

Adolescent health services differ from comparable services for adults in that they have greater potential for preventing injurious development simply because adolescents have shorter pasts and longer futures than adults. By the same token, any permanent damage suffered in adolescence is more severe if only because it is longer-lasting than the same damage would be if it occurred later in life. Four sources of physical or social-emotional damage are sufficiently prevalent among youth to be termed "special hazards."

Abuse, Neglect, Delinquency, and Sexual Exploitation

There is a common tendency to assume that the terms child abuse and child neglect refer to very young children, but adolescents are by no means free from any of the forms that such scapegoating may take. Reliable statistics on incidence are not yet available. The number of reported cases has increased sharply since reporting has been required and protected by law, but it appears unlikely that reporting will ever equal actual incidence.

EPSDT personnel are likely to see some of these cases among adolescents because they have then reached an age, size, or degree of maturity or desperation that enables them to assert themselves in one way or another. Those who run away, who engage in delinquent acts, or who directly defy abusing parents and fall into the hands of police, may be referred by juvenile courts or courts of domestic relations. With these adolescents, health personnel should be prepared to carry out a comprehensive health assessment including documentation of any abuse or neglect.

It may be quite otherwise with young people who present themselves directly to health staff for rescue, showing evidence of physical abuse or bringing complaints of sexual exploitation. In these cases, the health staff must itself initiate the rescue action. Administrative policy should be quite clear that "hot lines" to local police and to State protective

services should be open for immediate dealing with the emergency. Unless an established "shelter" is available, these already traumatized adolescents may find themselves housed in a detention center or in the local jail.

It is thus urgent for health professionals and protective service staff to work together closely in advance of emergencies to develop procedures for the most effective collaboration to ensure the safety and promote the recovery of young victims.

Accidents

As indicated in the table on page 50, accidents are the leading cause of death in adolescence. The doubling and tripling of accident rates from the younger to the older of the two age groups suggest the possible influence of more motor vehicle involvement, a suggestion further supported by the fact that the motor vehicle death rate is 42 per 100,000 population, while the rate for all other accidents is 17 per 100,000. Since driver education might serve to ameliorate that situation it should be a requirement for obtaining a driver's license. However, it would be shortsighted to overlook or discount the influence of other teen-age forces, such as the love of competition, the eagerness to take first place, the thrill of recklessness, the fear of looking "chicken" and even the sporadic willingness to embrace violence. It is not without significance that suicide and homicide also appear among the leading causes of death in the 15-19 year age group.

While there is obvious need to include accident prevention in all health education programs directed toward teen-agers, it is by no means clear how to achieve it. The statistics should be widely publicized and the adolescent traits just mentioned that contribute to accident-proneness should be explicitly identified in a non-judgmental way. Beyond this, it is largely left to the health staff to discern in the history and from direct questioning any evidence of deficits in impulse control or severe depression, if indicated, and to refer as soon as possible for psychiatric counseling. To whom to refer, when, how, and where, it is essential for health staff to have some training and orientation in the field of mental health. Accident proneness is heavily weighted with social-psychological factors and sequelae and cannot be dealt with effectively as a medical problem only. Cooperative agreements with resources for crisis intervention, evaluation, and more extensive mental health care should be established to facilitate prompt access to consultation and/or intervention.

Leading Causes of Death in Children and Youth

Age in Years	Cause	Deaths per 100,000 of Specified Age-Group			
		White		All Other	
		Males	Females	Males	Females
5 - 14	Accidents	21.7	10.5	29.0	12.4
	Cancer	6.1	4.1	4.7	3.9
	Congenital Anomolies	2.0	2.0	1.7	2.4
	Homicide	0.9	0.7	3.0	1.5
	Influenza & Pneumonia	0.9	1.0	1.2	1.3
	Diseases of the Heart	0.8	0.8	1.5	1.3
15 - 24	Accidents	97.1	26.4	76.0	19.2
	Suicide	19.2	4.9	14.7	4.0
	Homicide	10.6	3.6	70.2	17.0
	Cancer	8.0	5.2	7.7	4.8
	Diseases of the Heart	2.8	1.4	6.9	4.4
	Influenza & pneumonia	1.5	1.2	2.7	2.5

*Unpublished Work Tables, Mortality Statistics Branch, National Center for Health Statistics, HEW, 1976.

Drug and Substance Abuse

In numerous pocket areas in urban and suburban centers of this country, drug abuse among adolescents reached epidemic proportions more than a decade ago. Alcohol use is on the increase in the same age group as well as in others. Opinions vary as to which is the greater source of damage—the ingested (injected or inhaled) drug or substance, or the attitudinal set that leads to such use. Effective treatment combines the two approaches— medical treatment for the physical symptoms, and long-term counseling to aid in resolving the psychological problems. Unfortunately, effective treatment also depends heavily and indeed critically on the motivation of the adolescent. Few young people seek help until they have experienced at least one frightening acute episode, often involving some irreversible damage, and usually involving hospitalization.

EPSDT personnel are not likely to be much involved in drug emergency situations. Their primary function is to screen for incipient or potential drug-dependence. This is a delicate and difficult task against stiff resistance. It is not helpful for anyone to try to pin down suspicions. Questions about drug usage should be forthrightly put and answers recorded without comment unless the individual teen-ager seems to be inviting discussion or challenging disapproval. Both of these may be interpreted as an indirect way of seeking information. Thus, it may be appro-

priate to respond by giving factual information including any legalities that may be involved. However, since a significant component of the drug culture is the element of alienation, which is both cause and effect, there is a risk factor in further alienation by eliciting this information.

The important point in any such dicussion is to adhere to the factual, to avoid moralizing (which is always alienating), to attempt to assess the degree of the adolescent's vulnerability to stress, and to understand the pattern and efficiency of characteristic coping methods (e.g., how much boredom vs how much interest, how much isolation and loneliness vs how many and how deep friendships, how much self-confidence vs how much self-doubt, and what history of accidents, illnesses, depression, or pervasive pessimism vs, what evidence of happiness and hope). These are the kinds of questions that the screening staff should try to answer so that adolescents with a drug problem can be identified and referred for counseling to help solve the underlying problems that lead to drug and substance abuse.

If there is no local program for drug problems (preferably using ex-addicts and peer counseling) one should be established. The EPSDT provider then can work with or use consultation from this program.

Sexual Activity, Safeguards, Outcomes, and Options

Since the Social Security Act (42 USC § 139 d [a] d) clearly specifies that Medicaid-eligible sexually active minors are legally entitled to family planning services and supplies, informational material should identify family planning among the services available through EPSDT programs. The need is great. Each year over a million adolescent girls become pregnant, resulting in some 600,000 births to this high-risk group. Since eight out of every ten such pregnancies are acknowledged to be unintended, preventive action should be accorded high priority.

Sex Education

Sex education ideally should provide every adolescent with full information about the entire gamut of sexual activity and outcomes and their social-emotional components. It should also offer ample opportunity for questions and answers not only about the reproductive system and "planned parenthood", but also about masturbatory practices, homosexuality, contraception, abortion and veneral disease (see also pp. 42, 52, and 53). At a minimum it should include information about the human reproductive process, the chance of pregnancy following unprotected in-

tercourse, and the problems usually associated with pregnancy in the young. Where no better method appears feasible, such information can be provided in pamphlet form. The following resources may be of assistance:

American Public Health Association
1015 18th Street, N.W.
Washington, D.C. 20036

Office of Human Development Services
Administration for Children, Youth and Families
Donahoe Building, Room 3853
400 Sixth Street, S.W.
Washington, D.C. 20034

Planned Parenthood Federation of America, Inc.
810 Seventh Avenue
New York, N.Y. 10019

Sex Information and Education Council of the U.S. (SIECUS)
137-155 N. Franklin Street
Hamstead, Long Island, N.Y. 11550

Contraceptive Devices and Supplies

These should be available on request, together with instructions and advice about their use. Provision of these should never be just a cursory transaction. A care-taking attitude on the part of staff may encourage a care-taking attitude in the adolescent. This is a matter of no small importance. Essentially all studies made of pregnant adolescents indicate, by the girls' own testimony, that only 14% of them used contraceptives. As long as there is even a chance that some of this failure is due to confusion or lack of forethought, every effort should be made to inform young people fully about the various contraceptive methods and their differing advantages and risks.

The "pill" for example, is felt by some to be the most reliable method but must be taken regularly to be effective. It places full responsibility on the girl, and may carry some side-effects as well as some degree, not yet clearly determined, of risk from over-exposure to hormonal influences. Intra-uterine devices, similarly, may be quite effective, but again, they leave full responsibility with the girl. They also are subject to in-

voluntary expulsion with consequent risk of pregnancy, and may produce bleeding, dysmenorrhea, and pelvic inflammation. The condom, most effective when used in combination with a diaphragm or spermicidal foam, has the advantage of being readily available in drugstores, and divides the responsibility. But it also requires foresight and last-minute control. Unless adolescents are aware of the facts, they cannot make a rational choice of method or recognize when a change of method becomes advisable. In the process of thus thinking about contraception, they may become better prepared to benefit by it.

Pregnancy

Testing for pregnancy should be readily available, either at the EPSDT center or by referral to some nearby resource, and should be done as soon as pregnancy is suspected. This is a particularly opportune time to strengthen the relationship between the health staff and the adolescent. If test results are negative, there is occasion for reassurance and for reconsideration not only of contraceptive practice but of the implications of contraceptive failure for the girl's future. If findings are positive, the girl faces some difficult decisions whether alone, with a health professional, her partner, or her parents if they choose to be involved.

In the first place, she must decide whether to abort (if abortion is practicable) or to carry to term. In either case she is probably going to be troubled by some ambivalence about the decision and will need help in getting her life into new perspective. The health staff should be prepared to offer such help, or to assist the adolescent in obtaining such help through the use of other resources in the area. This should be done in individual counseling sessions and, wherever possible, in group discussions with other girls in a similar situation. In the second place, if she decides to carry to term or if, in effect, the decision is made for her (if, for example, she resides in a State that does not fund abortions and she has no funds of her own), she may still have to decide whether to keep her baby or to release it for adoption.

In either case she is going to need prenatal care and continuing support since adolescent pregnancy is high-risk physically as well as a time of most strenuous emotional involvement and psychological change. If her decision is to keep her child, a host of further questions follow. Is she ready to return to school or to work? If so, how is the baby to be cared for? What help can she realistically expect from the child's father, his family, her parents, or her friends? What living arrangements are possible for her and her baby? What interpersonal complications and

strains must be anticipated? What affectional bonds can be counted on to strengthen and sustain the young mother?

The need for continuing and supportive counseling for adolescent parents is as obvious and urgent as their need of training for parenthood. This includes training in child care, education about its frustrations and almost endless demands, education in child development, and safeguards against involuntary child abuse or neglect. The many hazards involved in too-early parenthood can hardly be overstated and health staff working with teen-age parents have no easy set of problems to deal with. They must be able to think, to assess, and to plan realistically as well as resourcefully. They must also be able to trust something to the amazing resiliency of youth. It is their strongest ally.

CHAPTER VII

DEVELOPMENTAL REVIEW

The complexities of the emotional development of the adolescent and the variables introduced by the peer pressure of which the adolescent is a part prevent a comprehensive discussion of the emotional and cognitive development of the adolescent in this document. However, in the context of the EPSDT program, developmental review is basically concerned with competence. That is, with how well the given individual meets the expectations, implicit as well as explicit, of society. It follows, necessarily, that the specific content of a developmental review will change over time as the individual changes and as social expectations increase.

Developmental review of a preschool child is relatively simple:[13] One appraises gross and fine motor skills, use of words and understanding of them, and perhaps degree of self-dependence. Society does not expect much of a young child. Developmental review of an adolescent is more complicated, not only because social expectations are more stringent and social sanctions more threatening, but also because adolescents themselves are really immeasurably complicated, contradictory, and volatile.

Nevertheless, since growth may falter or even become arrested during adolescence, and support of the right kind at the right time may serve to restore it to healthy functioning, it is important to ask what we need to learn in the course of a developmental review with an adolescent and how we can go about learning it.

The biological component of such a review has been covered in the preceding chapters along with recognition, occasionally, of certain relevant social and psychological factors. In this chapter, the social and psychological factors are brought into focus. However, it is acknowledged that there are no fully satisfactory screening devices or standard-

13. For the child under six, see "Developmental Review in the EPSDT Program," The American Association of Psychiatric Services for Children, Inc., The Medicaid Bureau, HCFA, HEW, April 1977; and "Implementing the Developmental Assessment Component of the EPSDT Program," by Beatrice D. Moore, *American Journal of Orthopsychiatry*, Vol. 48, No. 1, pp. 22-32, Jan. 1978.

ized procedures to help here. Where the EPSDT review staff includes a mental health professional, coverage of these dimensions may most properly be delegated to that professional. Where the staff includes no one with that special kind of expertise, it may be useful to review briefly the areas in which adolescent problems most commonly occur and which may cause the adolescent and the health staff to determine that there is need for use of additional resources for the adolescent.

Responsibility

One of the chief hallmarks of maturity is the willingness to accept responsibility and the capacity to carry it to a satisfactory conclusion. It is not very useful to ask directly if a young person is duly responsible, but there are often clues in the Introductory Health Questionnaire (pp. 11-12) which can be identified. Occasionally a teenager will blurt out a protest against being held responsible for "too much" which can lead into further discussion. One of the most important criteria, however, is the record of school attendance as the adolescent reports it. School drop-out is usually preceded by increasing frequency of non-attendance which is by no means always truancy. It is often with parents' permission or even collusion. An attitude toward school attendance or homework assignments may be so contemptuous that it quite dispenses with concealment or subterfuge.

This topic, then, may serve as a fairly comfortable entry into other psychosocial inquiry because it is likely to elicit an honest response from most teen-agers, and because it leads easily into exploring other areas of responsibility. It is, of course, of paramount importance that the health staff refrain from making value judgments about the advisability or the inadvisability of dropping out of school and concentrate instead on listening to the adolescent's own ideas and feelings about responsibility, using that term. It may well be the first time that anyone has invited such discussion.

Here again, as in the previously described screening procedures, the subject has a right to feedback as to the reasons for the questions and how the answers are interpreted. If the adolescent's self-report implies generally responsible behavior, that merits a passing comment about growth toward maturity. If there is scornful flouting of school obligations but responsible behavior in other areas, then referral for vocational counseling should be seriously considered. Often if the help comes at the right time, a youngster who is not achieving academically might prove to be interested in learning some trade or skill by which to earn a

living. State Vocational and Rehabilitation Services may be a useful resource in this regard. Finally, if the self-report suggests a pervasive and chronic failure to assume responsibility, a more searching evaluation is clearly in order. However, this will usually be just as clearly unacceptable to the adolescent. All that the health staff can do in such circumstances is to define the problem sympathetically as a reluctance to grow up when that means fending for oneself, and make a plan for follow-up.

It should be remembered that an adolescent coming voluntarily into the EPSDT program is in that very fact demonstrating some degree of responsibility, and an adolescent brought into the program by a parent has a parent with sense of responsibility who can perhaps be enlisted in the helping effort. If the health staff can somehow maintain a relationship, no matter how tenuous, with the adolescent, there is at least that much gained. There is the chance that the relationships may develop to a point where referral becomes acceptable or where the relationship itself becomes the vehicle by which the youth gradually become more dependable.

Achievement

While a sense of responsibility may certainly be a factor in achievement in school or at work, there are three additional reasons for considering achievement in a developmental review. In the first place it suggests something about how the adolescent spends time in activities which are productive to himself or others, or wastefully. Normally, children in their first five or six years in school seem to test just how much work they have to do to keep in good standing with others and with themselves. They may make good marks in one year, and feeling reassured, slacken effort. Then they get poorer marks, become anxious, and decide to make good marks again.[14] This uneven course gradually smooths out, however, so that most teen-agers have a fairly well established and characteristic achievement pattern. Most of them also have a fairly accurate perception of what that pattern is and it is not difficult to tell from the way they talk about school whether they are engaged and involved, or detached and more or less adrift. In the latter case, a further evaluation may be advisable.

In the second place, achievement in the adolescent years often reveals certain interests and aptitudes that can play a significant part in vocational choice. Again, it is worth noting that young people coming into the

14. See "Early Detection of Emotional Illnesses in School Children, Final Report," by Lorene A. Stringer and John C. Glidewell, St. Louis County Health Department, April 1967.

EPSDT program are "ipso facto" motivated and to some degree able to mobilize their efforts and energies. Usually they respond well to adult interest in the kind of career they may want to pursue or the kind of job they would like to get. There is wide variation in the quality of counseling available in schools or in the community. Where the quality is good, counseling can be strongly supportive of adolescent interests and ambitions. Where that support is lacking, it can sometimes be found within the adolescent's family, in a parent, an older sibling, or friend. Young people need a sense of direction even if it changes frequently. Amid all the uncertainties of adolescence the sense of direction may remain very thin and tenuous unless it receives some support, consensual validation, as it were, from outside.

Finally, although marked intellectual limitation is evident long before adolescence, it is unfortunately true that milder degrees of developmental delay may show up only as the demands on intelligence grow progressively more stringent. Where there is serious question of such limitation, referral should be made for full diagnosis. However, consideration should be given to the possibility of the child's emotional development limiting his demonstrated capabilities in the assessment setting.

Care should be taken to assure that all procedures involved in diagnosis meet the statutory requirements of the State in relation to discriminatory use of standardized tests referred to in the Educational Amendment of 1974 (P. L. 93.380, Section 614). Also, caution is required in the use of school data to avoid violation of the Family Educational Rights and Privacy Act of 1974 (Buckley Amendment). Consent of parent and child should be obtained before any request is made for school data.

In connection with mental retardation or other handicapping condition, one further point must be made. Parents who have been able to keep a moderately or severely handicapped child at home may become anxious as the child enters adolescence and shows signs of sexual curiosity. Referral may be indicated not only for counseling, but also for long-term planning. With the trend toward deinstitutionalization, increasing numbers of communities are developing a continuum of services including sheltered living and work opportunities for handicapped adolescents and adults. When the parent is not concerned about this particular problem, health staff have an obligation to raise the question and try to effect a referral.

Interpersonal Relationships

By this time in the contact, assuming that the screening process has followed approximately the order of these chapters, health staff should

have a fairly clear idea of what this particular adolescent is like, how ready or how slow to relate, how open or how withholding in responses, and how quick to comprehend or how easily confused. There may have been more specific clues as well, i.e., references to other people, family or friends, about whom one may now inquire in more detail.

Some assessment of the adolescent's language skills should be considered. Obviously the young person who can listen well, i.e., can be closely attentive when others speak and quick to grasp what they are trying to say, has an interpersonal skill that is lacking in the inattentive listener.

The verbally expressive person is going to be more versatile interpersonally than the unexpressive person. However, language skills do not ensure good relationships. They can, indeed, be used to exploit and deceive. Insofar as they are used in the service of better understanding and fuller communication, they facilitate learning and can promote more harmonious though more complex relationships in the course of time.

The adolescent years themselves are likely to be charged with interpersonal strains and dissonances. These with adults involve issues of dependence and authority; with peers, issues of intimacy. An adolescent engaged with both issues at the same time, as many are, is the center of a veritable maelstrom of turbulent and contradictory emotions. Rebellion against authority is so normal to this stage of development that its absence raises a serious question, namely, "is this docile teenager unwilling to leave childhood dependence, afraid to claim autonomy and self-control?" Similarly, about the loner and the habitual gang-adherent, one questions whether this youngster is too insecure to risk one-to-one intimacy. If there is to be continuing growth towards and through maturity, there apparently must be first conflict and ambivalence and then working through them to a new kind of peace with parents and permitting a new kind of comfort-in-intimacy with peers.[15]

To put a complex process as simply as possible, there are three developmental milestones in adolescent interpersonal relations: (1) the entry into change which, like the onset of puberty, does not occur at the same age for everyone, but varies widely between individuals; (2) the involvement in conflicts, sometimes lasting for several years (five to ten); and (3) the eventual resolution of conflict, optimally by discarding the childish patterns of relating and moving into the patterns of maturity.

It is not difficult to discern from the things that adolescents say about their families and friends approximately where they are among these mile-

15. See "Group Influence on Personality Development," by Juliette Favez-Boutonier, in *Mental Health and Infant Development*, ed. Kenneth Soddy, Basic Books, Inc., New York, 1956. See also *Lord of the Flies*, by William Golding, Capricorn Books, New York, 1959.

stones. There is no quick and easy way to ascertain if they are moving ahead or have been somehow arrested in their progress. Sometimes the parents can help in this if the young person agrees to a joint interview. Sometimes the parents can say if and how their teenager has changed in the past year in ways of getting along with others. Even if parents have not until then been very observant or alert to change, they along with their teenager may be helped to think about this developmental process, and thus become more observant and more understanding. This is a kind of health education that should not be overlooked or slighted.

Treatment of serious interpersonal difficulties calls for highly specialized skills and ample time. EPSDT staff should know who in the community can provide such treatment, and to whom to refer for counseling. There are a number of criteria for pompt referral: when there is acting-out to a dangerous degree (whether the danger is to the adolescent or to others); when a family has recently moved into the community and the teenager, having no friends, seems unable to make new friends; when there has been an impulsive rush into early marriage or parenthood; and when there are indications of unhappiness so acute, pervasive, and unremitting that it is tantamount to a cry for help.

Making an effective referral may itself call for interpersonal skills of a high order. The adolescent should be helped to understand clearly the reason for referral so that it is not misconstrued as suspicion of "craziness". Also, the desirability, if not the actual requirement, of parental consent and support should be pointed out. If the recommendation meets at first with unyielding resistance, effort should be made to move into the subject next outlined.

The Intrapersonal Balance

While it remains true that nothing seems more important to adolescents than the acceptance and approval of their peers, this is largely if not entirely because of their insatiable hunger to feel valued. There is nothing terribly reprehensible about that core need, which is certainly not peculiar to adolescents. It is inherent in every human being. In children, it is more subconscious and transparent, and is manifested by openly demanding attention or praise. In adolescents it is often a tyrannical drive of such impetuosity that it threatens to defeat its own aim by grabbing for too much too soon.

The question that adolescents have to deal with is how to establish their own value in the eyes of others without seeming to do so. The question itself, let alone all the operations it induces, is largely subconscious. To admit it to consciousness would be to acknowledge self-

doubt, which everyone else might take at face value. Instead, young people dissemble, still subconsciously. For every one who is still childish enough to be chasing the spotlight there will be another who seems overcome with timidity and anxious to escape attention. Another may clown, and yet another may manage to look detached, cool and somewhat amused. Each of them in these different ways is attempting to cope with the same longing to be first, to be best, to be loved and admired.

There is little doubt that the basic attitude toward self is set in the earliest years; or that the rejected baby becomes the adolescent who expects to be rejected, and the well-loved baby becomes the adolescent who takes peer-approval for granted. But basic patterns, although they may resist change, are not altogether immutable. Indeed, one of the hallmarks of mental health is the capacity to modify basic patterns to fit experience. With thoughful adolescents it is a nearly constant preoccupation to try to fit the inward perception of self to the outward evidence of other's reaction. In all the uncertainties of a changing self and changing others, it is small wonder that the day-by-day outcomes lead to wide mood-swings from exultation to despair and back again.

The mood-swings are to be expected. What the health staff need to know is their prevailing trend over time. Are the highs becoming less high and less frequent, the lows growing lower and more prolonged? This is not easy to assess if one sees an individual adolescent only once in a year or more and briefly then. One may sometimes assess mood swings with the question, "Do you like yourself a little better today than you did, say, a year ago?" attending not so much to the words of the response as to the accompanying affect. The question seems baldly direct, but it conveys the clear and perhaps to the teenager the surprising message that the health interviewer, a competent adult, considers it important to think well of oneself. Other often useful questions are: How are you different this year from last? Are you beginning, do you think, to live up to your parents' expectations? Are you beginning to live up to your own expectations? What successes have you had recently that especially pleased you? Just a few questions of this general tenor should suffice to distinguish the near-suicidal adolescent from those who are coping adequately with their ups and downs. The near-suicidal, of course, should be referred for psychiatric help, and every effort extended to assure that they make the connection.

For the others, there is one further issue to be determined, by inference, not by direct questioning: Is this young person learning from experience or is the infantile perception of self persisting, unmodified, in spite of evidence of its invalidity? If there were earlier indications of

pervasively difficult interpersonal relations, signs of deep-rooted jealousy and hatred, and there are now signs of inability to use current good experiences to counterbalance past bad experience, this fact should be pointed out and a follow-up appointment offered to talk it over again after the adolescent has had some time to think about it and to try a more constructive approach.

Here again, it may be helpful, with the adolescent's consent to bring in the parents for a joint interview. Sometimes what a child perceives as parental rejection has been altogether inadvertant on the parent's part and getting the misperception into the open allows for a genuine reconciliation. Where the parents are in fact rejecting, professional help must be directed toward the emancipation of the adolescent and, insofar as it is possible, a writing-off of old scores. On occasion, such emancipation itself leads to improved parent-child relations along with a significantly bettered self-perception in the adolescent.

Recreation

A salient factor all too often overlooked in the screening of adolescents is the variety, quantity, and quality of recreation. Most adolescents are gregarious and physically energetic so that team sports and group activities hold great attraction for them. They also offer constructive outlets for competitiveness and repeated encounters with reality in the context of fun, which makes reality sometimes easier to accept. Health staff should be fully knowledgeable about neighborhood houses, community centers, and other city or county facilities that offer such recreational opportunities and some adult leadership and initiative in them. It is not desirable and, indeed, it would only incite rebellion, to try to schedule and fill every hour of an adolescent's waking time. There should be a variety of recreational resources available, enough to allow some room for individual choice.

There should also be opportunities to pursue individual and sometimes solitary interests, i.e., music, reading, crafts, fishing trips, or camping trips. The list could go on and on. Many a youngster coming into the EPSDT system will come from a family whose "recreation" has been restricted to church affairs, tavern-sitting, or watching television. Such restriction is often an unnecessary deprivation. Its danger is twofold: (1) that excess energies, finding no satisfying outlet, may lead to boredom, and boredom to mischief or outright delinquency; and (2) that the capacity for enjoyment, finding little to nourish it, may gradually atrophy, taking with it whatever potential for creativity the young person may have

had. After all, it is in play that creativity first manifests itself and then flourishes.

Recreation should not be viewed as merely a luxury or a present. It is indispensable to health[16] and to health-maintenance, and therefore is an essential component of any truly comprehensive EPSDT system. If the initial question as to what the adolescent does for recreation elicits a bright and enthusiastic response, the youth may be given an expression of commendation with reference to the importance of a fair quota of fun. However, if the response indicates inadequate recreational resources or opportunities, then the health staff should explore further to determine what the adolescent might enjoy doing, and where, when, and how it might be arranged. Schools, churches, and service agencies usually offer some facilities and programs. For more individualized pursuits or for the occasional more esoteric interest, service organizations, arts councils, and public radio and television stations can sometimes be persuaded to assume sponsorship. Extreme care must be taken to ensure their understanding that they are sponsoring interest, not budding genius.

While drug abuse may occur in a "recreational" context under the guise of parties, drug abuse is unlikely to be revealed here if it has not been brought out earlier (see pages 50-51). However, there is one other situation that calls for referral for psychiatric help, namely, an apparent incapacity for enjoyment in anything or any one except perhaps sleep.[17] The absence of enjoyment in an adolescent should always be taken seriously unless it is quite clearly due to stressful circumstances of a temporary nature. It is not always easy to effect a referral in such case because apathy is a usual concomitant of the condition, but the effort should be made. Enlisting the aid of the parents may be of more significant help than anything short of referral.

The Brief Screening Interview

It is obvious from the foregoing material that a full developmental review is not only time-consuming, but also requires a number of specialized skills. In the EPSDT screening program, the challenge is to gain

16. See "Schizotaxin, Schizotypy, and Schizophrenia" by Paul Meehl, in *The American Psychologist* 17 (1962), pp. 827-838.

17. Adolescent sleep-patterns are often characteristically erratic, alternating several successive nights of short hours with prolonged, nearly around-the-clock slumbering. These are natural and do not call for intervention. Sleep-disturbances, however, especially insomnia and nightmares, should be taken seriously if they are more than occasional. Brief psychotherapy is to be preferred over tranquilizers or sedatives, which leave the underlying problem untouched. Excessive sleeping is usually pathognomic of depression and sudden onsets of sleep may point to narcolepsy. Both conditions should be promptly referred for full evaluation.

enough understanding in the course of an interview that may last no more than fifteen minutes to determine whether an adolescent should be referred for full developmental evaluation.

The interviewer's approach should be open and straight-forward, inviting the adolescent's participation in what may be called either "a brief mental health check-up" or "a brief developmental review." If there were earlier clues to a particular problem area, they should now be reconsidered in depth enough to determine how best to deal with them. If there were no such clues, then the order in which the various parameters have been discussed here is an easy and natural order to follow.

It may be helpful to some interviewers and with some adolescents to use a form like the following, provided that it is clearly understood to reflect only estimates based on partial information.

Estimated Psychosocial Strengths

Variable	Rater Appraisal				
	1	2	3	4	5
	Below Average		Average		Above Average
Responsibility					
Achievement					
Interpersonal relationships					
Intrapersonal balance					
Recreation					

Ultimately, however, the decision to refer, monitor, or give a clean bill of health, rests on how the adolescent relates to the interviewer, assuming the interviewer relates well; and most importantly, that the interviewer is either a member of the adolescent's cultural or ethnic group or is clearly sensitive to and accepting of the values of this subculture. If the adolescent is unwilling to accept referral, the interviewer can do no more than monitor his/her course and look for a more propitious time to refer.

The brief screening interview should at least open the way to subsequent contacts, both on a regular re-screening basis and at need. Then however imprecise and incomplete the interview may otherwise have been, it will have served its therapeutic aim.